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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 2/21/17 through 2/23/17. An extended survey was conducted on 2/27/17 through 2/28/17. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 100 certified bed facility was 87 at the time of the survey. The standard survey sample consisted of 15 current Resident reviews (Residents 1 through 15) and 5 closed record reviews (Residents 16 through 20). The expanded survey sample consisted of 6 current Resident reviews (Residents 21 through 26).	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is,	F 157	1. Resident #7s family has been made aware of the residents significant weight gain noted in December 2016. Resident #3's physician and responsible party have been made aware of the resident's falls on 4/21/16 and 07/27/16. Even with the significant weight gain Resident #7's family continues to bring in fast food and "goodies" for the resident. Resident #3 is at hight risk for falls d/t his behavior as a result of his brain injury. The physician and responsible party are aware of his condition and the nursing staff makes every effort to provide a safe environment for the resident.	02/22/17 02/24/17 02/22/17

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Virginia M. Snead — TITLE: Administrator — (X6) DATE: 3/28/17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to contin program participation.

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F 157	Continued From page 1 a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to notify the physician and/or responsible party of a change in resident condition for two of 26 residents in the survey sample, Residents #7and #3. 1. The facility staff failed to notify Resident #7's physician and responsible party of the resident's	F 157	2. The Unit Manager will audit all weights and falls to assure that the responsible parties and physicians have been notified. 3. All nursing staff will be inserviced by the DON/ADON on notification of family and physician for accidents/incidents, change in condition, change of any orders transfer or discharge. Nursing staff will also be inserviced on the need to document the notifications in the residents medical record. 4. Incidents/accidents and weights are received weekly in risk management notification of RP and MD will be part of the review process in risk management The QA committee will monitor this processes quartertly.	03/22/17 03/29/17 03/22/17

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
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F 157	Continued From page 2 significant weight gain noted in December 2016. 2. The facility staff failed to notify Resident #3's physician and RP (responsible party) following falls that occurred on 4/21/16 and 7/27/16. The findings include: 1. The facility staff failed to notify Resident #7's physician and responsible party of the resident's significant weight gain noted in December 2016. Resident #7 was admitted to the facility on 6/23/14 and readmitted to the facility on 6/18/15. Resident #7's diagnoses included but were not limited to: dementia with lewy bodies (1), Parkinson's disease (2), generalized anxiety disorder and history of falling. Resident #7's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/24/16, coded the resident as being severely cognitively impaired, scoring a three out of a possible 15 on the brief interview for mental status. Section K coded the resident as having a weight gain of 5% or more in the last month or 10% or more in the last six months. The MDS documented the resident was not on a physician prescribed weight gain regimen. Review of Resident #7's clinical record revealed a weight report that documented the resident weighed 160.7 pounds on 6/6/16 and weighed 184.7 pounds on 12/7/16 (a 12.9% weight gain in six months). A progress note signed by the dietary manager on 12/19/16 documented, "Quarterly Review-nursing notes weight 185 # (pounds). > (Greater than) 10% (percent) since last review. Diet	F 157		

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downgraded by SLP (speech language pathologist) to mechanical soft (chopped). Tolerating current texture well. Receives all meals in assisted dining room. Fed by staff all meals with typical intake of 75-100%. Family continues to bring in mcdonald's but offers resident milk shakes due to current diet texture. Not able to communicate needs so staff anticipates them. Family very involved with care. No recommendations needed at this time."

A weight change note signed by the registered dietician on 12/29/16 documented, "Resident accepting 75%-100% of meals as fed by self and as received on a mechanical soft diet with no problems indicated. Resident with a new wt (weight) of 185 # indicating wt gain of 24 # past 6 months. No edema indicated...Suspect wt gain r/t (related to) appetite. No new recommendations at this time. Monitor."

Further review of dietary notes and nurses' notes failed to reveal documentation that Resident #7's physician or responsible party was made aware of the resident's significant weight gain.

On 2/27/17 at 1:35 p.m., an interview was conducted with OSM (other staff member) #4 (the dietary manager). OSM #4 stated typically the registered dietician will review residents for weight gains and will write a note reflecting those reviews. OSM #4 stated the unit managers were responsible for notifying the physician and responsible party of residents' weight gains.

On 2/27/17 at 3:44 p.m., an interview was conducted with RN (registered nurse) #5. RN #5 was asked about the process followed by staff for notifying the physician and responsible party in

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cases of a resident's significant weight gain. RN #5 stated if a resident had congestive heart failure then she would notify the physician according to parameters per physician's orders. RN #5 stated she never had to notify the physician regarding a generalized weight gain from food intake and she had only notified the physician about weight gain related to cardiac concerns or edema (swelling). RN #5 was asked about family notification. RN #5 stated she would probably notify the resident's family in passing. RN #5 stated Resident #7's family brings in "goodies" for the resident and wants the resident to be happy. RN #5 stated she didn't recall notifying Resident #7's physician or responsible party regarding the resident's significant weight gain noted in December 2016.

On 2/27/17 at 5:50 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

On 2/28/17 at 7:45 a.m., an interview was conducted with RN #7; regarding what circumstances she would notify a resident's physician and responsible party. RN #7 stated she would notify the physician and responsible party regarding falls, skin tears, new orders, changes in therapy and any significant changes. When asked if she would notify the physician and responsible party regarding a resident's significant weight gain, RN #7 stated nurses entered weights into the computer system and then the weights were discussed in the risk management meetings.

The facility document titled, "Protocol for Notifying Physician and Responsible Party" documented,

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F 157	Continued From page 5 "1. The MD (medical doctor) and RP (responsible party) are to be notified with any change in condition or change of orders. 2. The MD and RP are to be notified of any incident that involves the resident. 3. Documentation of this notification should be in the resident chart or in any investigative reports for incidents. 4. The 3-11 (3:00 p.m. to 11:00 p.m.) shift charge nurse or supervisor (if available) will call all responsible parties with the new orders written on a daily basis. 5. The MD and RP will be notified of any incident involving a resident as soon as possible after the incident occurs. This must be documented in the resident record..." No further information was presented prior to exit. (1) "Lewy body disease is one of the most common causes of dementia in the elderly. Dementia is the loss of mental functions severe enough to affect normal activities and relationships. Lewy body disease happens when abnormal structures, called Lewy bodies, build up in areas of the brain..." This information was obtained from the website: https://medlineplus.gov/lewybodydisease.html (2) "Parkinson's disease (PD) is a type of movement disorder. It happens when nerve cells in the brain don't produce enough of a brain chemical called dopamine..." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=parkinson%27s+disease 2. The facility staff failed to notify Resident #3's physician and RP (responsible party) following	F 157		

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F 157	Continued From page 6 falls that occurred on 4/21/16 and 7/27/16. Resident #3 was admitted to the facility on 8/9/13 with a readmission on 4/20/15 with diagnoses that included, but were not limited to; left craniotomy (1) (the surgical removal of part of the bone from the skull to expose the brain), high blood pressure, aphasia (difficulty with talking), glaucoma (a disease of the eye causing blindness), heart disease, agitation, a traumatic brain injury, and difficulty swallowing. Resident #3's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 1/27/17. Resident #3 was coded as being unable to complete the Section C, Cognitive Patterns, BIMS (brief interview for mental status) and Resident #3 was coded by staff as being severely cognitively impaired. Resident #3 was coded as being totally dependent of two people with bed mobility. A review of Resident #3's clinical record revealed, in part, a facility Neurological Flow Sheet initiated on 4/21/16 at 0000 (midnight). The flow sheet documented that Resident #3 was assessed on 4/21/16 at 0000 (midnight), 0100 (1:00 a.m.), 0500 (5:00 a.m.), 0900 (9:00 a.m.), 1300 (1:00 p.m.) and 1700 (5:00 p.m.) for level of consciousness, movement, hand grasps, pupil size (both right and left), speech, blood pressure, pulse, respirations and oxygenation. Further review of Resident #3's clinical record did not reveal any documentation as to why the Neurological Flow Sheet had been initiated and did not reveal any documentation that the medical doctor (MD) or Resident #3's RP had been notified of the need to perform the Neurological	F 157		

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F 157	Continued From page 7 Flow Sheet. A review of Resident #3's nursing progress notes revealed, in part, the following documentation; "7/27/2016. 10:18 PM. Resident had hit head earlier and neuro (neurological) checks are being completed every hour. Resident is stable; fully conscious, all extremities moving, hand grasps strong, PERRLA (pupils equal, round, and reactive to light and accommodation), speech clear, and vitals normal." Signed electronically by LPN (licensed practical nurse) #8. Further review of Resident #3's clinical record failed to reveal any documentation how Resident #3 hit his head. In addition the clinical record did not reveal any documentation that the MD or RP had been notified that Resident #3 had hit his head and was requiring "neuro checks" to be performed. On 2/22/17 at approximately 5:00 p.m. an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 was asked what should happen if a resident falls. ASM #2 stated, "The fall should be reported to the MD and RP and an incident report completed." ASM #2 was asked to provide any documentation for Resident #3's incidents dated 4/21/16 and 7/27/16. On 2/27/17 at approximately 2:30 p.m. an interview was conducted with LPN (licensed practical nurse) #8. LPN #8 was asked to review her progress note dated 7/27/16 and to explain what had occurred for Resident #3 to have hit his head. LPN #8 stated that he had fallen. LPN #8 further stated that she had initiated the neuro checks and did an assessment on the resident	F 157		

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(Resident #3). LPN #8 was asked whether or not the MD or RP had been notified. LPN #8 was unable to state that they had been notified of the incident.

On 2/27/17 at 3:15 p.m. an interview was conducted with ASM #2, the director of nursing. ASM #2 was asked if she had any information regarding any incidents with Resident #3 dated 4/21/16 and 7/27/16. ASM #2 stated that she could not find any documentation about any incidents.

On 2/27/17 at 5:50 p.m. an end of the day meeting was conducted with ASM #1, the administrator, ASM #2, the director of nursing, LPN #2, the north wing unit manager, OSM (other staff member) #4, the dietary manager, OSM #7, the business manager and OSM #1, the director of maintenance. The administrative staff was made aware of the concern and a policy on MD / RP notification was requested.

On 2/28/17 at 7:45 a.m. an interview was conducted with LPN #3, a charge nurse on the north unit. LPN #3 was asked to describe the process staff followed when a resident in the facility fell or had a change in condition. LPN #3 stated, "I assess the situation, assess the resident, call the MD and the RP." LPN #3 was asked if she would document her actions. LPN #3 stated that she would document in her progress notes what she had done and that she had notified the MD and RP.

On 2/28/17 at 11:25 a.m. an interview was conducted by phone with LPN #10, the nurse caring for Resident #3 on 4/21/16. LPN #10 was asked to describe the process followed when a

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resident in the facility fell or had a change in condition. LPN #10 stated, "I would write a note, do an incident report (if necessary), and notify the MD and RP." LPN #10 was asked if she remembered Resident #3 having a fall on 4/21/16. LPN #10 stated that she did not remember anything about him (Resident #3) falling. LPN #10 was asked what circumstances she would initiate and a Neurological Flow Sheet, LPN #10 stated "for a fall." LPN #10 was asked if she would document her actions. LPN #10 stated that she would document in the progress notes what had happened and that she had notified the MD and RP.

A review of the facility document titled "Protocol for Notifying Physician and Responsible Party" revealed, in part, the following documentation; "1. The MD and RP are to be notified with any change in condition or change of orders. 2. The MD and RP are to be notified of any incident that involves the resident. 3. Documentation of this notification should be in the resident chart or in any investigative reports for incidents. 5. The MD and RP will be notified of any incident involving a resident as soon as possible after the incident occurs. This must be documented in the resident record."

No further information was requested prior to the end of the survey process.

(1) This information was obtained from the following website; http://www.hopkinsmedicine.org/healthlibrary/_procedures/neurological/craniotomy_92,p08767/

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F 221	Continued From page 10	F 221		
F 221 SS=D	483.10(e)(1), 483.12(a)(2) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). 42 CFR §482.12, 483.12(a)(2) The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. (a) The facility must- (1) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to	F 221	1. A plan for an attempt to remove seat belt from resident #7. Unit Manager will assess resident #7 for his continued need for a seat belt. The seat belt will be removed and resident monitored by nursing staff for safety while up in wheelchair. Resident #7 will be reassessed for the appropriate interventions if he experiences any incidents in the future while up in wheelchair. 2. At this time there are zero residents with restraints in use. 3. The nursing staff will be inserviced by the DON or designee on policy and proceedure for restraint use to include the importance of elimination as the goal. 4. Weekly risk management will review any restraint orders and Interdisciplinary team will work towards elimination. The QA committee will monitor quarterly.	03/21/17 03/22/17 03/29/17 03/22/17

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ensure residents were free from restraints for one of 26 residents in the survey sample, Resident #7.

The facility staff failed to attempt a restraint elimination and/or reduction for Resident #7's wheelchair seatbelt although the resident was deemed a good candidate on November 2016 and February 2017 "physical restraint elimination evaluations".

The findings include:

Resident #7 was admitted to the facility on 6/23/14 and readmitted to the facility on 6/18/15. Resident #7's diagnoses included but were not limited to: dementia with lewy bodies (1), Parkinson's disease (2), generalized anxiety disorder and history of falling. Resident #7's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/24/16, coded the resident as being severely cognitively impaired, scoring a three out of a possible 15 on the brief interview for mental status. Section P documented Resident #7 utilized a trunk restraint daily.

Review of Resident #7's clinical record and fall investigations revealed the resident sustained three falls since the last standard survey (3/10/16) (two falls out of bed and one fall while out of the facility with family).

Further review of Resident #7's clinical record revealed a physician's order summary signed by the physician on 1/13/17 that documented an order dated 11/3/15 for "Self releasing seat belt.

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Special Instructions: self releasing seatbelt when in w/c (wheelchair) Every Shift..." The summary also documented an order dated 11/18/15 to "Check and release seat belt for safety, routinely, all shifts..."

Resident #7's comprehensive care plan with a problem start date of 9/28/16 documented, "HIGH FALL RISK R/T (related to) CONFUSION; COMBATIVE BEHAVIOR; INCREASED ANXIETY; PSYCHOTROPIC MEDS (medications); VISION LOSS; SEVERAL FALLS SINCE ADMIT; RESIDENT TRIES TO GET OUT OF HIGH BACK W/C (wheelchair) DURING EPISODES OF ANXIETY; REACHES FOR OBJECTS/PERSONS CAUSING TO LEAN FORWARD; (sic) ORDER FOR SELF RELEASE SEATBELT WHEN UP IN W/C (RESTRAINT CONSENT SIGNED D/T (due to) RESIDENT NOT ALWAYS ABLE TO RELEASE ON COMMAND)...Approach: MONITOR RESIDENT CLOSELY WHILE UP IN HIGHBACK W/C WITH SELF RELEASE SB (seatbelt); IF RESIDENT SEEMS ANXIOUS/RESTLESS PUT HIM TO BED..." The care plan failed to document information regarding elimination and/or reduction of the seatbelt.

Resident #7's physical therapy progress notes for dates of service from 8/30/16 through 9/12/16 failed to document information regarding restraint elimination and/or reduction.

Resident #7's physical restraint elimination evaluations dated 11/18/16 and 2/15/17 documented, "INSTRUCTIONS: Restraint use requires review on an ongoing basis to determine if a less restrictive or total elimination of restraint use is deemed appropriate. For each category,

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F 221	Continued From page 13 evaluate resident; then circle the corresponding number that best describes his/her current status. Total the column of numbers to determine candidate status and restraint use reduction or elimination. Continue evaluation and review on the reverse side of form." The form documented the following categories of evaluation and correlating scores: Ambulation: wheelchair mobile with assist- a score of two Weight Bearing/Transfers: partial weight bearing/assist of one for transfer- a score of one Bed Mobility: No category or score was documented Sitting Balance: leans to a side, forward, backward- a score of three ADLs (activities of daily living) (Bathing, dressing, grooming): requires total assist of two- a score of three Physical Limitations: history of falls- a score of three Vision Status: adequate with glasses/without glasses- a score of zero Orientation: disoriented times two spheres- a score of two Comprehension: directions must be frequently repeated- a score of one Behavior/Mood: combative/severely agitated- a score of three Activity Participation: unable to actively participate- a score of two Medication Therapy: currently taking antipsychotics (3)- a score of five Medication Therapy: currently taking antidepressants (4)- a score of five The total score for both evaluations was not documented on the form; however, calculation of the total score equaled 30 for both evaluations.	F 221		

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F 221	Continued From page 14 According to the form, a score between 21 and 35 indicated the resident was a good candidate for restraint reduction and/or elimination. The reverse side of the form documented: "1. Candidate status as determined by TOTAL SCORE on reverse." Check boxes were located beside the options of "Priority" "Good" and "Poor." None of the boxes were checked. "2. Candidate for restraint reduction or elimination program?" Check boxes were located beside the options of "Yes" and "No." None of the boxes were checked. "Plan of Care Updated." Check boxes were located beside the options of "Yes" and "No." None of the boxes were checked. "If Yes (the resident was a candidate for a restraint reduction or elimination program); Date program to start (no date documented)." "Restraint consent signed?" Check boxes were located beside the options of "Yes" and "No." None of the boxes were checked. "Action Plan: Continue w/c (wheelchair) seatbelt." "Least restrictive measures to be used" Nothing was documented. "If No (the resident was not a candidate for a restraint reduction or elimination program); State specific reason, medical symptoms or targeted behavior: Lewy Body Dementia, combative." On 2/21/17 at 4:36 p.m., Resident #7 was observed in a high back wheelchair in the day room with staff supervision. The resident's seatbelt was undone. On 2/22/17 at 8:47 a.m., Resident #7 was observed being wheeled in a high back wheelchair into the dining room. The resident's seatbelt was not visible due to his shirt covering the area.	F 221		

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F 221	Continued From page 15 On 2/22/17 at 4:50 p.m., an interview was conducted with CNA (certified nursing assistant) #3. CNA #3 was asked if Resident #7 could remove his seatbelt. CNA #3 stated this depended on the resident's state of mind; sometimes he could and sometimes he could not. CNA #3 stated she releases the resident's seatbelt every two hours. When asked if facility staff had ever attempted a reduction regarding the resident's seatbelt, CNA #3 stated she wasn't aware if a reduction had been attempted. On 2/27/17 at 1:05 p.m., Resident #7 was observed being wheeled in a high back wheelchair. The resident's seat belt was secure. On 2/27/17 at 2:20 p.m., an interview was conducted with OSM (other staff member) #2 (an occupational therapist). OSM #2 was asked if the therapy department had played any role in addressing Resident #7's need for a restraint. OSM #2 stated the restraint hadn't been addressed "per se" but the resident had previously been "looked at" for positioning. When asked why Resident #7 had a seatbelt, OSM #2 stated she hadn't seen (worked with) the resident for some time but he knew the physical therapist had worked with the resident. No occupational therapy notes were present in Resident #7's clinical record so OSM #2 was asked to review Resident #7's physical therapy notes and show this surveyor if the therapist had addressed the resident's seatbelt. OSM #2 pointed to a sentence on a physical therapy progress report with dates of service from 8/30/16 through 9/12/16 that documented, "Pt (Patient) and Caregiver Training: Patient and caregiver educated on proper posture, proper mobility,	F 221		

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proper transfer, proper gait to improve functional mobility and enhance safety awareness." OSM #2 stated the statement was more general and didn't specifically address the seatbelt. When asked if restraint elimination or reduction attempts should be made, OSM #2 stated he would rather try an anti-thrust cushion that increased friction and if he came across a resident with a seatbelt then he would evaluate the seatbelt (Note- Resident #7 did have a pommel cushion in the wheelchair per physician's order).

On 2/27/17 at 3:44 p.m., an interview was conducted with RN (registered nurse) #5 (unit manager). RN #5 stated when Resident #7's seatbelt was initiated she had to complete an assessment to see if the resident was able to release the belt by himself. RN #5 stated the resident was not able to do so, so she had to complete a restraint assessment, notify the physician, and receive consent from the family. RN #5 stated each quarter she completes restraint elimination assessments to see if the seatbelt is still needed or if the seatbelt can be removed. RN #5 stated she usually involves the therapy staff when a restraint is initiated but confirmed she had not involved the therapy staff in Resident #7's case. RN #7 stated she also evaluates the resident to see if he has had multiple falls, if his medical condition has changed, and if his diagnoses have improved, worsened or stayed the same. RN #5 was asked to explain the process for completing the quarterly restraint elimination assessment. RN #5 stated she reads each section of the form to see which areas relate to the resident then she adds the score. When asked how she utilizes the score, RN #5 stated she utilizes the

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score/recommendation if she feels the restraint can be eliminated but she doesn't remove the restraint if it's not safe to do so. When asked what should be done if the score indicates the resident is a good candidate for restraint elimination, RN #5 stated she may remove the restraint but will leave the restraint in place if the resident continues to fall. RN #5 stated she chose to leave Resident #7's seatbelt in place due to falls. When asked why she hadn't attempted a trial reduction such as releasing the resident's seat belt for various periods of time to see how the resident responded, RN #5 stated that thought had come to her mind and was something good to keep in mind for the future.

On 2/27/17 at 5:50 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

On 2/28/17 at 7:45 a.m., an interview was conducted with RN #7. RN #7 was asked to interpret Resident #7's seatbelt order. RN #7 stated she couldn't say the resident's seatbelt was released every two hours because the order didn't state that but incontinence care has to be provided every two hours and the seatbelt must be released in order to do so.

On 2/28/17 at 8:28 a.m., an interview was conducted with LPN (licensed practical nurse) #8 (a nurse who routinely cared for Resident #7). LPN #8 confirmed the resident was unable to unbuckle his seatbelt. LPN #8 was asked to interpret Resident #7's seatbelt order. LPN #8 stated as far as she knew, the resident was put in his wheelchair and removed from his wheelchair several times a shift including when incontinence

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F 221	Continued From page 18 care was provided. The facility policy titled, "Restraints [including Side Rails]" documented, "PURPOSE: The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms [Code of Federal Regulations: 483.13 (a)]. Professional standards of practice have eliminated the need for restraints except under limited circumstances. Therefore, medical symptoms that would warrant the use of restraints must be reflected in the comprehensive assessment and care planning. For those residents whose care plans indicate the need for restraints [to treat medical symptoms] the nursing facility will engage in a systematic and gradual process toward reducing the use of restraints [in type of restrictive device or technique and/or in length of time that the restraint is used]...4. Physical restraint reduction/elimination assessments will be done for residents who require the use of restraints to treat a medical symptom. a) At least quarterly with the MDS/Care Plan review and as needed on anyone with a restraint who demonstrates a need to change restraint usage. b) Nursing or a rehabilitative therapist will complete the physical restraint reduction/assessment with input from the interdisciplinary team, resident, and/or family as appropriate. The assessment shall demonstrate resident outcome from restraint usage and explore potential reduction/elimination and alternatives. If the restraint cannot be reduced/eliminated the clinical record will demonstrate continued observation of the medical symptom and or/behavior that the restraint device is treating..."	F 221		

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F 221	Continued From page 19 No further information was presented prior to exit. (1) "Lewy body disease is one of the most common causes of dementia in the elderly. Dementia is the loss of mental functions severe enough to affect normal activities and relationships. Lewy body disease happens when abnormal structures, called Lewy bodies, build up in areas of the brain..." This information was obtained from the website: https://medlineplus.gov/lewybodydisease.html (2) "Parkinson's disease (PD) is a type of movement disorder. It happens when nerve cells in the brain don't produce enough of a brain chemical called dopamine..." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=parkinson%27s+ (3) "Antipsychotic medicines (also known as neuroleptics) are primarily used to manage psychosis. The word "psychosis" is used to describe conditions that affect the mind, and in which there has been some loss of contact with reality, often including delusions (false, fixed beliefs) or hallucinations (hearing or seeing things that are not really there)..." This information was obtained from the website: https://www.nimh.nih.gov/health/topics/mental-health-medications/index.shtmldisease (4) "Antidepressants are medicines that treat depression..." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=antidepressants	F 221		

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F 252 SS=E	483.10(e)(2)(i)(1)(i)(ii) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT (e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. (i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and facility document review, it was determined that the facility staff failed to ensure a clean, comfortable, home like environment in two of four shower rooms in the facility. The facility staff failed to provide an environment within the ladies whirlpool room on the north unit that was free from foul odors and failed to maintain a tidy, clean environment in the ladies whirlpool room on the south unit. The findings include; On 2/23/17 a tour was conducted of the four facility shower rooms as part of the general	F 252	1. All whirlpool rooms have been thoroughly cleaned by housekeeping. The shower C.N.A's have been instructed on maintaining a tidy clean enviroment at all times while bathing residents and when all baths are complete. 2. The Unit Manager or designee will inspect the shower rooms on both units periodically during the day and at the end of the bathing day. A flowsheet will be used to document shower room checks. 3. C.N.A's will be inserviced by ADON on the importance of maintaining a clean enviorment for residents. The enviornmental director will instruct his staff on the times to pick up laundry and trash barrels from the units to prevent ordors and maintain a clean order-free environment. The environmental staff will pick up filled trash and linen barrels at 745a.m. 11:00am and 230pm. They will return clean barrels. A schedule for maintaining a clean environment has been written and the staff has been educated as stated above. 4. The whirlpool rooms and all barrels will be monitored daily by the unit manager or designee and the enviromental director or designee. Both will report to the risk management committee weekly and QA committee quarterly. The DON or designee will spot check these areas during the week.	03/1/17 03/22/17 03/22/17 03/22/17

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observations of the facility. At 12:40 p.m. this surveyor entered the shower room identified as "ladies whirlpool room" on the north unit. On entering there was a very strong foul odor. There were seven large barrels (three yellow, one white and three gray) observed as one entered into the room. The whirlpool tub was located to the right of the room and the barrels were observed on the left side of the room, leaving a very narrow space to pass between the barrels and the whirlpool tub. The gray barrels were all full and contained clear trash bags that were filled with soiled diapers and other assorted trash. The yellow barrels were all full and contained soiled linen. A second surveyor was asked to enter the room to verify the intensity of the odor and to observe the barrels in the room. LPN (licensed practical nurse) #1, the wound care nurse, was seated at the nurses station and was asked if residents used the ladies whirlpool room, LPN #1 stated that they did.

On 2/23/17 at 12:45 p.m. LPN #2, the unit manager, was observed to enter the ladies whirlpool room carrying a small clear trash bag, tied at the top, containing a soiled diaper. LPN #2 came out of the room without the trash bag that was in her hand when she entered into the room.

On 2/23/17 at 12:50 p.m. CNA (certified nursing aide) #32 was asked who used the ladies whirlpool room. CNA #32 stated that the residents on the north unit used the shower rooms on Mondays, Tuesdays, Thursdays and Fridays. CNA #32 further stated that there were two shower aides and they used both the ladies and the mens whirlpool rooms on the north unit. CNA #32 was asked where the soiled diapers and linen were placed following ADL (activities of daily

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F 252	Continued From page 22 living) care. CNA #32 stated, "We dispose of any trash (diapers) into the trash bag in the resident's room, we tie the bag and then take it to a gray barrel either in the hallway or in the ladies whirlpool room. CNA #32 was asked what the yellow barrels were for, CNA #32 stated, "Dirty linen." CNA #32 was asked where the barrels are normally stored, CNA #32 stated that they sometimes kept two gray barrels at the end of the hallway, but most times the barrels were kept in the whirlpool rooms. On 2/23/17 at 1:00 p.m. an interview was conducted with CNA #8, the shower aide. CNA #8 was asked whether or not she had completed her showers for the day. CNA #8 stated that she had finished them all in the morning. CNA #8 was asked which shower/whirlpool room she had used. CNA #8 stated she had used the ladies whirlpool room (north unit). CNA #8 accompanied this surveyor into the north unit ladies whirlpool room and was asked to identify the barrels. CNA #8 stated the yellow and white barrels were for soiled linen and the gray barrels were for trash. CNA #8 was asked why the barrels were in the shower room, CNA #8 stated, "To dispose of soiled linen and other soiled items (diapers) when giving a shower. Usually we keep a set of barrels at the end of each hallway but when they get full then we use the barrels in the shower room." CNA #8 was asked if she showered residents with the barrels in the room today. CNA #8 stated that she did. CNA #8 was asked who was responsible for moving the barrels when full. CNA #8 stated, "The yellow ones are taken down by laundry at 11:00 a.m. and then laundry returns the empty barrels to the shower rooms. The gray barrels are moved when full, we have to notify maintenance to come take them." CNA #8 was	F 252		

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asked if there was an odor in the room. CNA #8 stated, "No, I don't smell anything." The three gray barrels were opened and verified to be full of trash. CNA #8 stated, "These barrels need to be removed."

On 2/23/17 at 1:15 p.m. CNA #5 was asked to enter into the ladies whirlpool room on the north unit with this surveyor. CNA #5 was asked if she could smell any odors. CNA #5 stated, "It smells like urine and poopoo (feces)." CNA #5 was asked if she would be happy to be showered in this room, CNA #5 stated no. CNA #11 entered the ladies whirlpool room at this time and was asked if she smelled any odor. CNA #11 stated, "It smells like urine and feces, not good." When asked if she would care to be showered in this room, CNA #11 stated no.

On 2/23/17 at approximately 1:20 p.m. an observation was made of the south unit shower rooms. This surveyor entered the south unit ladies whirlpool room with CNA #7. CNA #7 was asked if the residents were bathed / showered in this room. CNA #7 stated that they were. A clear trash bag filled with used diapers was lying on the floor of the shower room. Inside the whirlpool tub an opened clean diaper was lying on the bottom of the tub. A second clear trash bag was observed on the floor filled with soiled clothes. In the shower area a broken razor was on the floor. CNA #7 was asked about each item, CNA #7 stated, "the bags should have been picked up after the showers were done and removed to the soiled utility room, we have a sharps box and all the used razors should be placed in the sharps box." CNA #7 was asked whether or not any of these items were supposed to be on the floor. CNA #7 stated that they should not be left on the

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floor. CNA #7 further stated that all items should be removed from the shower room immediately following the showers.

On 2/27/17 at 5:50 p.m. an end of the day meeting was conducted with ASM #1, the administrator, ASM #2, the director of nursing, LPN #2, the north wing unit manager, OSM (other staff member) #4, the dietary manager, OSM #7, the business manager and OSM #1, the director of maintenance. The administrative staff was made aware of the concern and a policy on maintaining a clean, homelike environment for the residents was requested.

On 2/28/17 at 4:35 p.m. an interview was conducted with LPN #11. LPN #11 was asked who was responsible for keeping the shower rooms clean. LPN #11 stated that the aide giving the showers cleans up when finished.

On 2/28/17 at 4:40 p.m. an interview was conducted with OSM #1, the director of maintenance. OSM #1 was asked if he was responsible for housekeeping, OSM #1 stated that he was. OSM #1 was asked who was responsible for cleaning the shower rooms. OSM #1 stated that the aides giving the showers were responsible for picking up and cleaning between and after showers. Once all showers were done housekeeping cleaned the rooms.

A facility procedure titled "Daily maintenance - central baths and whirlpool" documented, in part, the following; "Purpose; To maintain clean, hygienic and attractive surroundings." There were no policies or procedures provided that addressed the barrels in the shower rooms or the trash on the floor.

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F 252	Continued From page 25 No further information was provided prior to the end of the survey process.	F 252		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a	F 278	1. For resident # 3 the MDS annual with ARD 4/28/16 and the revised quarterly MDS with ARD of 01/27/17 have been corrected to show that 1he resident did have falls during the look back period. The care plan has been updated to include the above fall dates. 2. The MDS coordinators have audited the MDS and care plans of all residents who have documented falls to assure that the falls where captured on the MDS in the look back period and care plans were revised with interventions. 3. All licensed nursing staff have been inserviced on documentation of falls and completing incident/accident reports as well as notifiaction of RP and MD. The MDS coordinatiors will get verbal report daily from both Unit Managers in addition to receiving a copy of the Incident/Accident reports to keep them up to date on the past 24 hours. The MDS coordinators have been educated on the importance of reading documentation in the chart before completing the MDS. The MDS Coordinators are to use the RAI Manual for guidance when completing the MDS and Care Plan.	03/22/17 03/22/17 03/29/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 278	Continued From page 26 material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to provide a complete and accurate comprehensive assessment for one of 26 residents in the survey sample, Resident #3. Resident #3 was documented in the clinical record as having falls on 4/21/16 and 1/04/17. The facility staff failed to code these falls on Resident #3's annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 4/28/16 and his quarterly MDS assessment with an ARD of 1/27/17. The findings include: Resident #3 was admitted to the facility on 8/9/13 with a readmission on 4/20/15 with diagnoses that included, but were not limited to; left craniotomy (1) (the surgical removal of part of the bone from the skull to expose the brain), high blood pressure, aphasia (difficulty with talking), glaucoma (a disease of the eye causing blindness), heart disease, agitation, a traumatic brain injury, and difficulty swallowing. Resident #3's most recent MDS (minimum data set) is a quarterly assessment with an ARD (assessment reference date) of 1/27/17. Resident #3 was coded as being unable to complete the Section C, Cognitive Patterns, BIMS (brief interview for mental status) and Resident #3 was coded by staff as being severely cognitively impaired. Resident #3 was coded as being totally dependent of two people with bed mobility. Resident #3 is coded in Section J, Health	F 278	4. The 24 hour report for the previous week will be reviewed by the risk management committee to assure accuracy of Incident/Accident reports and any occurances that may not have been reported. The MDS Coordinators are in attendance at these meetings. The QA committee will monitor quarterly.	03/22/17

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F 278	Continued From page 27	F 278		

Conditions, as having no falls since the prior assessment. A review of Resident #3's annual MDS with an ARD of 4/28/16 revealed in Section J, Health Conditions, that Resident #3 was coded as having no falls since the prior assessment.

A review of Resident #3's clinical record revealed, in part, a facility Neurological Flow Sheet initiated on 4/21/16 at 0000 (midnight). The flow sheet documented that Resident #3 was assessed on 4/21/16 at 0000 (midnight), 0100 (1:00 a.m.), 0500 (5:00 a.m.), 0900 (9:00 a.m.), 1300 (1:00 p.m.) and 1700 (5:00 p.m.) for level of consciousness, movement, hand grasps, pupil size (both right and left), speech, blood pressure, pulse, respirations and oxygenation.

Further review of Resident #3's clinical record did not reveal any documentation as to why the Neurological Flow Sheet had been initiated on 4/21/16.

A review of Resident #3's nursing progress notes revealed, in part, the following documentation; "1/4/2017 4:46 p.m. Writer called to room by staff, resident found in floor on knees on mat, bed in the lowest position, fall alarms in place and functioning, no injuries noted."

A review of Resident #3's comprehensive care plan with a revision date of 5/3/16 did not reveal any documentation regarding a fall occurring on 4/21/16.

A review of Resident #3's comprehensive care plan with a revision date of 2/1/2017 did not reveal any documentation regarding a fall occurring on 1/4/17.

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F 278	Continued From page 28	F 278		

On 2/27/17 at 5:50 p.m. an end of the day meeting was conducted with ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, LPN (licensed practical nurse) #2, the north wing unit manager, OSM (other staff member) #4, the dietary manager, OSM #7, the business manager and OSM #1, the director of maintenance. The administrative staff was made aware of the concern and a policy completing the MDS assessments was requested at this time.

On 2/27/17 at 3:15 p.m. an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 was asked if she had any information regarding any incidents with Resident #3 dated 4/21/16 and 1/4/17. ASM #2 stated that she could not find any documentation for the 4/21/16 fall, but there was a nurse's note for the incident on 1/4/17. No incident reports for either incident were provided.

On 2/28/17 at 9:00 a.m. an interview was conducted with LPN #9, the MDS coordinator. LPN #9 was asked how she captured relevant information when completing the MDS assessment. LPN #9 stated that in between assessments she would make notes on the care plan and then refer to her notes when it was time to complete the MDS assessment. LPN #9 was asked how she captured falls for correct coding on the MDS assessment. LPN #9 stated, "I typically put the falls on the care plan if I am made aware of when the falls occur. I will also get a copy of the incident reports for any incidents, such as falls. I also receive the falls tracking sheet or whatever is communicated by the unit manager." LPN #9 was asked to review Section J of Resident #3's MDS assessments with ARDs of 4/28/16 and 1/2717. LPN #9 stated

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F 278	Continued From page 29	F 278		

that Resident #3 is not coded as having falls on either assessment. LPN #9 was shown the documentation regarding Resident #3's falls that occurred on 4/21/16 (neurological flow sheet) and 1/4/17. LPN #9 stated, "I was not aware of the falls on 4/21/16 and 1/2717." LPN #9 was asked whether or not the falls should have been captured on the MDS assessments with ARDs of 4/28/16 and 1/27/17. LPN #9 stated that they should have been included. LPN #9 was asked what she used as a reference to complete the MDS assessments. LPN #9 stated that she used the RAI (resident assessment instrument) manual as a reference.

On 2/28/17 at 11:25 a.m. an interview was conducted by phone with LPN #10, the nurse caring for Resident #3 on 4/21/16. LPN #10 was asked to describe the process followed when a resident in the facility fell or had a change in condition. LPN #10 stated, "I would write a note, do an incident report (if necessary), and notify the MD and RP (medical doctor and responsible party)." LPN #10 was asked if she remembered Resident #3 having a fall on 4/21/16. LPN #10 stated that she did not remember anything about him (Resident #3) falling. LPN #10 was asked what circumstances she would initiate and a Neurological Flow Sheet, LPN #10 stated "for a fall." LPN #10 was asked if she would document her actions. LPN #10 stated that she would document in the progress notes what had happened and that she had notified the MD and RP.

No further information was provided prior to the end of the survey process.

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F 278	Continued From page 30 (1) This information was obtained from the following website; http://www.hopkinsmedicine.org/healthlibrary/_procedures/neurological/craniotomy_92,p08767/	F 278		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	F 279	1. Resident #2 has had the care plan revised to include delerium as triggered and checked in the CAA Section V of the annual MDS with ARD of 10/28/16. 2. The MDS coordinatiors will audit CAAs and care plans to assure any triggered area has been care planned as stated in the RAI manual. 3. The RAI manual sets forth the guidelines for completion of the MDS and Care plans The DON or designee reviewed Chap 4 of the RAI manual with the MDS Coordinators. This Chapter deals with Care Area Assessments Process and Care Planning. 4. Upon Completion of the comprehensive assessment with CAAs the MDS Coordinator will double check for care planning of all triggered areas. The DON or designee will review for completness. The QA committee will monitor quarterly.	03/22/17 03/22/17 03/29/17 03/22/17

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F 279	Continued From page 31 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to develop a comprehensive care plan from a triggered CAA (care area assessment) for one of 26 residents in the survey sample, Resident #2. The facility staff failed to develop a comprehensive care plan for the triggered care area of delirium, in Section V - Care Area Assessment (CAA), on Resident #2's annual	F 279		

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F 279	Continued From page 32 MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/28/16. The findings include; Resident #2 was admitted to the facility on 10/6/15 with a readmission on 10/20/15 with diagnoses that included, but were not limited to, heart failure, an infection of the urinary tract, dementia and dysphagia (difficulty with swallowing). Resident #2's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 1/24/17. Resident #2 was coded as scoring a one out of a possible score of 15 on the BIMS (brief interview for mental status), indicating that she was severely cognitively impaired. Further review of Resident #2's MDS assessments revealed an annual MDS assessment with an ARD of 10/28/16 revealed in Section V - Care Area Assessment (CAA) that "01 Delirium" was checked as a triggered care area under column "A" and also checked under column "B. Care Planning Decision." The instruction provided in Section V states, "2. For each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care area. Check column B if the triggered care area is addressed in the care plan." Section V, Column B for Resident #2's MDS was checked for delirium. A review of Resident #2's comprehensive care plan dated 11/7/16 did not reveal any	F 279		

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F 279	Continued From page 33 documentation regarding delirium. An interview was conducted on 2/27/17 at 11:50 a.m. with LPN (licensed practical nurse) #9, the MDS coordinator. LPN #9 was asked how she determined what needed to be care planned for a resident. LPN #9 stated that she care planned areas that triggered on the CAA worksheet in Section V of the MDS assessment. LPN #9 was asked to review Resident #2's comprehensive MDS assessment with an ARD of 10/28/16, specifically Section V. LPN #9 was asked if the areas checked in column B should be care planned. LPN #9 stated they should be care planned. LPN #9 was asked to evidence where delirium, a triggered area, was documented in Resident #2's comprehensive care plan. LPN #9 reviewed the 11/7/16 care plan and stated that it was not care planned. A review of the facility document titled "Care Planning - Resident" revealed, in part, the following documentation; "STANDARD Each Resident has a Resident Care Plan that is current, individualized, consistent with the medical regimen and updated as needed but at least every 90 days for each resident." There was no documentation that addressed creating care plans off of triggered areas in Section V of a comprehensive MDS assessment. On 2/27/17 at 5:50 p.m.an end of the day meeting was conducted with ASM #1, the administrator, ASM #2, the director of nursing, LPN #2, the north wing unit manager, OSM (other staff member) #4, the dietary manager, OSM #7, the business manager and OSM #1, the director of maintenance. The administrative staff was made aware of the concern and a policy completing the	F 279		

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F 279	Continued From page 34 comprehensive care plan was requested at this time. No further information was provided prior to the end of the survey process.	F 279		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or	F 280	1. The Care plan for resident #3 has been revised and the falls on 4/21/16 and 7/27/16 have been addressed in the falls care plan 2. The MDS Coordinators have reviewed all documented falls and checked for appropriate care planning 3. All nursing staff has been inserviced on facility protocol for falls, documentation, care planning and follow up. 4. The risk management committee will review all falls in the weekly meeting and check the care plans during the meeting for care plan and intervention.	03/22/17 03/29/17 03/29/17 03/22/17

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F 280	Continued From page 35 resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 280		

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F 280	Continued From page 36 disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to review and revise the comprehensive care plan for one of 26 residents, Resident #3. Resident #3 fell on 4/21/16 and 7/27/16 and the facility staff failed to review and revise the comprehensive care plan to address the falls when they occurred. The findings include; Resident #3 was admitted to the facility on 8/9/13 with a readmission on 4/20/15 with diagnoses that included, but were not limited to; left craniotomy (1) (the surgical removal of part of the bone from the skull to expose the brain), high blood pressure, aphasia (difficulty with talking), glaucoma (a disease of the eye causing blindness), heart disease, agitation, a traumatic brain injury, and difficulty swallowing. Resident #3's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 1/27/17. Resident #3 was coded as being unable to complete the Section C, Cognitive Patterns, BIMS (brief interview for mental status) and Resident #3 was coded by staff as being severely cognitively	F 280		

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impaired. Resident #3 was coded as being totally dependent of two people with bed mobility.

A review of Resident #3's clinical record revealed, in part, a facility Neurological Flow Sheet initiated on 4/21/16 at 0000 (midnight). The flow sheet documented that Resident #3 was assessed on 4/21/16 at 0000 (midnight), 0100 (1:00 a.m.), 0500 (5:00 a.m.), 0900 (9:00 a.m.), 1300 (1:00 p.m.) and 1700 (5:00 p.m.) for level of consciousness, movement, hand grasps, pupil size (both right and left), speech, blood pressure, pulse, respirations and oxygenation.

Further review of Resident #3's clinical record did not reveal any documentation as to why the Neurological Flow Sheet had been initiated on 4/21/16.

A review of Resident #3's nursing progress notes revealed, in part, the following documentation; "7/27/2016. 10:18 PM. Resident had hit head earlier and neuro checks are being completed every hour. Resident is stable; fully conscious, all extremities moving, hand grasps strong, PERRLA (pupils equal, round, and reactive to light and accommodation), speech clear, and vitals normal." Signed electronically by LPN (licensed practical nurse) #8.

Further review of Resident #3's clinical record did not reveal any documentation how Resident #3 had hit his head and did not reveal that the MD or RP (medical doctor and responsible party) had been notified that Resident #3 had hit his head and was requiring "neuro checks" to be performed.

A review of Resident #3's comprehensive care

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plan with a revision date of 5/3/16 did not reveal any documentation related to Resident #3's fall on 4/21/16.

Further review of Resident #3's comprehensive care plan with a revision date of 8/8/16 did not reveal any documentation related to Resident #3's fall on 7/27/16.

On 2/27/17 at 11:50 a.m. an interview was conducted with RN #4 (registered nurse), the MDS coordinator. RN #4 was asked when a comprehensive care plan would be revised. RN #4 stated that the care plan would be reviewed and revised with any changes in therapy, any incidents. RN #4 was asked how she would learn about changes in therapy or incidents, RN #4 stated, "I learn about changes / incidents in the weekly risk management meeting and I also review the doctor's orders. If a resident has a fall it should show up on the tracking form." RN #4 stated she would review Resident #3's information and get back with this surveyor.

On 2/27/17 at 3:40 p.m. RN #4, the MDS coordinator, stated that she could not find any review or revisions to Resident #3's comprehensive care plan to reflect the falls that occurred on 4/21/16 and 7/27/16.

On 2/27/17 at 5:50 p.m. an end of the day meeting was conducted with ASM #1, the administrator, ASM #2, the director of nursing, LPN #2, the north wing unit manager, OSM (other staff member) #4, the dietary manager, OSM #7, the business manager and OSM #1, the director of maintenance. The administrative staff was made aware of the concern and a policy for the review and revision of comprehensive care plans

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F 280	Continued From page 39 was requested at this time. A review of the facility document titled "Care Planning Resident" revealed, in part, the following documentation; "STANDARD Each resident has a Resident Care Plan that is current, individualized, (sic) consistent with the medical regimen and updated as needed but at least every 90 days for each resident." There was no documentation regarding when or how a resident's comprehensive care plan should be reviewed and revised based on changes in therapy or incidents. No further information was provided prior to the end of the survey process. (1) This information was obtained from the following website; http://www.hopkinsmedicine.org/healthlibrary/_procedures/neurological/craniotomy_92,p08767/	F 280		
F 282 SS=E	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to follow the written plan of care and/or failed to	F 282	1. Resident # 7 staff was made aware of the importance of having bed pad alarm turned on and fall mats to both sides of bed while resident is in bed. Also while up resident is to have latera(side support in place. The charge nurse signs the alarms, mats, and lateral side support off on the treatment sheets. The unit manager will observe the resident each day to assure all devices are in use when resident is in wheelchair or in bed. Resident #6 the physician was made aware of the the failure to obtain an albumin level on 9/28/16 as ordered. Another order was obtainined and the lab was drawn on 10/18/16	03/22/17

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F 282	Continued From page 40 ensure services were provided by qualified professionals for four of 26 residents in the survey sample, Resident #7, Resident #6, Resident #13 and Resident #4. 1.a. The facility staff failed to follow Resident #7's written plan of care for the implementation of a bed alarm and a fall mat. b. The facility staff failed to follow Resident #7's written plan care for the implementation of left lateral side support while in the wheelchair. 2. For Resident #6, facility staff failed to follow the written plan of care and obtain an Albumin [1] Level Laboratory Test that was ordered by the physician per dietary recommendation on 9/28/16. 3. For Resident #13, facility staff failed to ensure weekly skin assessments were conducted by a licensed nurse. CNAs performed the weekly skin assessments. 4.a. The facility staff failed to follow the written plan of care for the administration of oxygen for Resident #4. b. The facility staff failed to ensure that weekly skin assessments for Resident #4 were performed by qualified individuals. CNAs performed the weekly skin assessments. The findings include: 1.a. The facility staff failed to follow Resident #7's written plan care for the implementation of a bed alarm and a fall mat.	F 282	Resident #13 has expired 2/28/17. Resident #4 has her O2 flow at 2L/ min via nasal cannnula as ordered. The charge nurses are signing off the oxygen on the treatment sheets but have been instructed to check the flow before signing off. The unit Manager will do follow up to assureO2 flow is correct. Resident #4 is currently being followed weekly by the wound care MD. The treatment nurse is doing treatments as ordered and completing weekly assesments with measurements. When the treatment nurse is not in the facility, the charge nurse does the treatment 2. A 100% audit of all residents by the unit manager and DON or designee to assure all residents have the order safety devices, supportive devices, correct oxygen flow, and ordered lab work. The evening and night shift charge nurses will do skin assestments on all residents. The Treatment Nurse will complete a 100% audit of all resident with skin breakdown and assure weekly assessments and measurements are complete. 3.The Nursing staff has been inserviced by DON or designee on the standard of care for nursing staff. When the treatment sheets are signed off by the charge nurse it means that the order is being carried out as written. Assessments are done by the licensed nurses not C.N.A's. Care plans are written to assistt all nursing staff in giving care to the residents. All physicians orders must be carried out as ordered on the date ordered. If this is not possible another order must be obtained to D/C the order and another order written. Standards must be maintained In order to provide safe effective nursing care. The Treatment Nurse has been instructed on the expectations of a nurse in her position. Weekly measurements must be done on all skin breakdown. Education on wound staging and the difference between wounds caused by pressure and wounds that are caused by non-pressure. The wound care physcician is assisting with this educations.	03/29/17 03/29/17

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F 282	Continued From page 41 Resident #7 was admitted to the facility on 6/23/14 and readmitted to the facility on 6/18/15. Resident #7's diagnoses included but were not limited to: dementia with lewy bodies (1), Parkinson's disease (2), generalized anxiety disorder and history of falling. Resident #7's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/24/16, coded the resident as being severely cognitively impaired, scoring a three out of a possible 15 on the brief interview for mental status. Section G coded Resident #7 as requiring extensive assistance of two or more staff with bed mobility, transfers and walking in the corridor. Review of Resident #7's clinical record revealed a physician's order summary signed by the physician on 1/13/17 that documented orders for a bed pad alarm and fall mats at bedside while the resident was in bed. Resident #7's comprehensive care plan with a problem start date of 1/6/17 documented, "HIGH FALL RISK R/T (related to) CONFUSION; COMBATIVE BEHAVIOR; INCREASED ANXIETY; PSYCHOTROPIC MEDS (medications); VISION LOSS; SEVERAL FALLS SINCE ADMIT...Approach: BED/FALL ALARMS ON PER ORDER; MONITOR RESIDENT FOR TAKING ALARMS OFF AND REPLACE AS NEEDED; ENSURE THE ALARM IS IN GOOD WORKING ORDER AND TURNED ON; CHANGE BATTERIES AS NEEDED; FALL MATS BESIDE BED AS ORDERED..." On 2/22/17 at 2:20 p.m. and 3:50 p.m., Resident #7 was observed lying in bed. The resident's bed alarm was off and there was no fall mat present on the right side of the bed.	F 282	4.The DON or designee will monitor the nursing staff's performance on a weekly basis. The treatment nurse will report to the Risk Managment committee weekly on all wounds. The QA committee will monitor quarterly.	03/22/17

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F 282	Continued From page 42 On 2/22/17 at 4:40 p.m., an interview was conducted with CNA (certified nursing assistant) #3 (the CNA caring for Resident #7). CNA #3 was asked how she was made aware of the safety devices required for each resident. CNA #3 stated the nurse will pass that information on to the CNAs and the CNAs have a book they can reference that includes which residents should have fall alarms, bed alarms and fall mats. CNA #3 was asked which safety devices were supposed to be implemented for Resident #7. CNA #3 stated the resident was supposed to have a clip fall alarm, bed pad alarm, bolsters, a pommel cushion wedge in the chair and fall mats. When made aware Resident #7 was observed in bed twice with the alarm off and the fall mat not on the floor, CNA #3 stated prior to this interview she had noted the resident was yelling and had slid off the pillow and his body wasn't aligned in the bed. CNA #3 stated during this time, the resident's bed pad alarm was not sounding. CNA #3 further stated she didn't recall picking the resident's fall mat up off the floor when she got the resident out of bed. On 2/27/17 at 3:44 p.m., an interview was conducted with RN (registered nurse) #5. RN #5 was asked how nursing staff was made aware of the safety devices required for each resident. RN #5 stated the nursing staff is notified as soon as a device is implemented, discontinued or changed. RN #5 stated sign-off books for devices were located at the nurse's station and regularly updated. RN #5 was asked the process for ensuring staff followed residents' care plans. RN #5 stated this was the responsibility of the charge nurse but everyone had access to the information. RN #5 stated nurses could pass the	F 282		

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F 282	Continued From page 43 information on to CNAs during report to make sure care planned interventions were in place. On 2/27/17 at 5:50 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility document titled, "CARE PLANNING-RESIDENT" documented, "STANDARD: Each resident has a Resident Care plan that is current, individualized, consistent with the medical regimen and updated as needed but at least every 90 days for each resident...Resident Care Plan is located on the Nursing Units for easy availability..." No further information was presented prior to exit. (1) "Lewy body disease is one of the most common causes of dementia in the elderly. Dementia is the loss of mental functions severe enough to affect normal activities and relationships. Lewy body disease happens when abnormal structures, called Lewy bodies, build up in areas of the brain..." This information was obtained from the website: https://medlineplus.gov/lewybodydisease.html (2) "Parkinson's disease (PD) is a type of movement disorder. It happens when nerve cells in the brain don't produce enough of a brain chemical called dopamine..." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=parkinson%27s+disease	F 282		

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b. The facility staff failed to follow Resident #7's written plan of care for the implementation of left lateral side support while in the wheelchair.

Review of Resident #7's clinical record revealed a physician's order summary signed by the physician on 1/13/17 that documented an order for the resident to have left lateral side support at all times while up in the wheelchair.

Resident #7's comprehensive care plan with a problem start date of 1/6/17 documented, "HIGH FALL RISK R/T (related to) CONFUSION; COMBATIVE BEHAVIOR; INCREASED ANXIETY; PSYCHOTROPIC MEDS (medications); VISION LOSS; SEVERAL FALLS SINCE ADMIT...Approach: LEFT LATERAL SIDE SUPPORT AT ALL TIMES WHILE UP IN W/C (Wheelchair)..."

On 2/22/17 at 9:25 a.m. and 12:40 p.m., Resident #7 was observed in a high back wheelchair in the day room. No left lateral support positioning device was observed in the resident's wheelchair. The resident's elbow was wedged against the back of the wheelchair and the arm rest.

On 2/22/17 at 4:50 p.m., an interview was conducted with CNA (certified nursing assistant) #3 (the CNA caring for Resident #7). CNA #3 was asked how she was made aware of what type of positioning devices were required for each resident. CNA #3 stated usually she knows but could ask the nurse if she had a question. CNA #3 stated the therapy department in-services staff when a new positioning device is implemented. CNA #3 was asked if Resident #7 was supposed to have any positioning devices. CNA #3 stated

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at one point in time the resident had a "side piece" that was positioned down in the resident's wheelchair to aid with positioning because the resident leaned to the side. CNA #3 confirmed the resident did not have the device placed in the wheelchair when she put him in the wheelchair and she didn't know what had happened to the device.

On 2/22/17 at 3:44 p.m., an interview was conducted with RN (registered nurse) #5. RN #5 was asked how nursing staff was made aware of what type of positioning devices were required for each resident. RN #5 stated nurses should see orders for the devices in the physician's orders and on the treatment administration record. RN #5 stated the nurses should pass that information on to CNAs during report to make sure the positioning devices are in place. RN #5 was asked the process for ensuring staff followed residents' care plans. RN #5 stated this was the responsibility of the charge nurse but everyone had access to the information. RN #5 stated nurses could pass the information on to CNAs during report to make sure care planned interventions were in place.

On 2/27/17 at 5:50 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

No further information was presented prior to exit.

2. For Resident #6, facility staff failed to follow the written plan of care and obtain an Albumin [1] Level Laboratory Test that was ordered by the physician per dietary recommendation on

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F 282	Continued From page 46 9/28/16. Resident #6 was admitted to the facility on 6/28/13 and readmitted on 1/5/17 with diagnoses that included but were not limited to high cholesterol, CVA (stroke), seizure disorder, aphasia [2], Multiple Sclerosis [3] and altered mental status. Resident #6's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/8/16. Resident #6 was coded as being cognitively impaired in the ability to make daily decisions scoring 04 out of 15 on the BIMS (Brief interview for mental status) exam. Resident #6 was coded as requiring extensive assistance with transfers, dressing, and eating, and was coded as being totally dependent on staff for bathing. Review of Resident #6's clinical record revealed the following physician telephone orders: "Received Date: 9/23/16, Start Date: 9/28/16 Order Description: Other Test: (Albumin), Frequency Once-One Time. Special Instructions: Per dietary recommendation." This order was created and verified by RN (Registered Nurse) #7. Review of Resident #6's clinical record failed to reveal that the Albumin level was obtained. Review of Resident #6's Nutrition care plan dated 9/20/16 and updated 11/30/16, documented the following intervention: "Approach start date: 9/20/16 MEDS (medications)/LABS (laboratory tests)/WEIGHT PER ORDER." On 2/23/17 at 11:35 a.m., LPN (licensed practical nurse) #5 was interviewed. When asked if the plan of care is to be followed by all staff, she	F 282		

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F 282	Continued From page 47 stated: "Yes." On 2/23/17 at 3:09 p.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). ASM #2 stated, "I couldn't find that lab that was requested on 9/28. It wasn't done." When asked why the laboratory test was not completed, ASM #2 stated, "I don't know, I was off that day." On 2/27/17 at 10:19 a.m., an interview was conducted with LPN #4. When asked the process of obtaining a laboratory test, LPN #4 stated that orders for laboratory tests get put into the computer system and the UM (unit manager) usually draws the labs on certain lab days or for STAT (immediate labs). LPN #4 stated that once the laboratory test is obtained, it is placed in a box for an outside laboratory company to pick up and process. LPN #4 stated that the results are faxed to the facility and the physician is made aware of the results by nursing staff. On 2/27/17 at 12:05 p.m., an interview was conducted with RN (registered nurse) #7. When asked about the process of obtaining a physician ordered laboratory tests. RN #7 stated that when a physician orders a lab for a resident, the lab will be put onto a list and the list will get transcribed onto the laboratory calendar for residents to be drawn on that particular day. RN #7 stated that Resident #6's lab (Albumin level ordered on 9/28/16) was an oversight on her part. RN#7 stated that Resident #6 did not make it to the calendar. On 2/27/17 at 3:44 p.m., an interview was conducted with RN (registered nurse) #5. RN #5 was asked the process for ensuring staff followed	F 282		

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F 282	Continued From page 48	F 282		

residents' care plans. RN #5 stated this was the responsibility of the charge nurse but everyone had access to the information.

On 2/23/17 at 3:09 p.m., ASM (administrative staff member) #2, the DON (Director of Nursing) was made aware of the above concerns. No further information was presented prior to exit.

According to Potter and Perry's, Fundamentals of Nursing, 7th Edition, page 269 states "A written care plan communicates nursing care priorities to other health care professionals. The nursing care plan enhances the continuity of care by listing specific nursing interventions needed to achieve the goals of care. The complete care plan is the blueprint for nursing action. It provides direction for implementation of the plan plus the framework for evaluation of the client's response to nursing actions."

[Albumin]-Is the main protein in blood plasma. Low levels occur in conditions associated with malnutrition, inflammation, liver and kidney diseases. This information was obtained from the National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0023211/.

[Aphasia]-Aphasia is a disorder caused by damage to the parts of the brain that control language. It can make it hard for you to read, write, and say what you mean to say. It is most common in adults who have had a stroke. Brain tumors, infections, injuries, and dementia can also cause it. This information was obtained from the National Institutes of Health. https://medlineplus.gov/aphasia.html.

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F 282	Continued From page 49 [Multiple Sclerosis]- Multiple sclerosis (MS) is a nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS. This information was obtained from The National Institutes of Health. https://medlineplus.gov/multiplesclerosis.html. 3. For Resident #13, facility staff failed to ensure weekly skin assessments were conducted by a licensed nurse. Resident #13 was admitted to the facility on 8/4/16 and readmitted on 2/14/17 with diagnoses that included but were not limited to metabolic encephalopathy [1], Pressure Ulcer Stage IV of the sacral region [2], Parkinson's disease, high blood pressure, prostate cancer, and dementia. Resident #13's most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 2/20/17. Resident #13 was coded as being severely impaired in the ability to make daily decisions scoring 03 on the Staff Interview for Mental Status Exam. Resident #13 was coded as requiring total dependence on one to two facility staff with transfers, bed mobility, locomotion on the unit, dressing, eating, personal hygiene and bathing. Review of Resident #13's clinical record revealed the following nursing note dated 2/4/16 at 3:05 a.m., "Resi (Resident) is A&O x 1 (alert and	F 282		

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F 282	Continued From page 50 oriented to self). Resi is able to communicate some needs. Resi is resting in bed with eyes closed at this time. Resp (Respirations) even and non-labored on RA (Room Air). HOB (Head of Bed) slightly elevated for comfort and to facilitate lung expansion. Resi continue to receive LTC (long term care) services r/t (related to) multiple Dx (diagnoses): to include prostate cancer, HTN (hypertension), dementia, high cholesterol and Parkinson's Disease. No s/sx (signs or symptoms) of distress or discomfort noted at this time. No c/o (complaints) pain voiced when questioned. Skin warm and dry to touch. Area noted to resident's sacrum and scrotum, resi positioned on side and note for treatment nurse to evaluate. Other treatments applied per MD (medical doctor) orders, resi tolerated well..." Review of a non-pressure skin condition report for Resident #13 documented the following: "Date First Observed: 2/4/17, Site/Location: Inner, upper, sacral fold. (Will have Dr. (Name of wound care MD) eval (evaluate) 2/9/17. Condition is a..." A check mark was documented under "Abrasion" indicating that two of the areas were found to be abrasions. A check mark was also documented under "Old scar" indicating that one of the areas was an old scar. Further review of the non-pressure skin condition report for Resident #13 documented the following: "Date: 2/4/17, Size in cm (centimeters) 0.1 x 0.1 x 0, Exudate type: None, Exudate amount: None, Tunneling: 0, Undermining: 0, Wound Bed: Pink/Beefy red, Surrounding Skin Color: Normal for skin, Surrounding tissues/wound edges: Normal for skin. Culture sent: No, Progress: New, Treatment: Continue treatment, Comments: Top, Pin-point area sacral	F 282		

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F 282	Continued From page 51 fold, Triad paste q (every) shift, Pinpoint area. Date: 2/4/17, Size in cm (centimeters) 2.0 x 1.0 x 0, Exudate type: None, Exudate amount: None, Tunneling: blank, Undermining: blank, Wound Bed: black/brown, Surrounding Skin Color: Normal for skin, Surrounding tissues/wound edges: Normal for skin. Culture sent: No, Progress: New, Treatment: Continue treatment, Comments: Scar area to sacral fold, scar area-firm, not mushy or boggy. Triad paste q (every shift). Date: 2/4/17, Size in cm (centimeters) 0.6 x 0.3 x 0.1, Exudate type: None, Exudate amount: None, Tunneling: 0, Undermining: 0, Wound Bed: Pink/Beefy Red, Surrounding Skin Color: Normal for skin, Surrounding tissues/wound edges: Normal for skin. Culture sent: No, Progress: New, Treatment: Continue treatment, Comments: Small abrasion at lower end of scar area. Triad q (every) shift." This non-pressure assessment was completed by the wound care nurse, LPN (licensed practical nurse) #1. Review of the Weekly CNA Skin Assessment sheet dated 2/2/17, prior to the sacral area found on 2/4/17, documented the resident as having an old skin tear to his left arm. No areas were identified to the sacrum. Nursing skin assessments from a licensed nurse could not be found prior to the discovery of the sacral area found on 2/4/17. On 2/27/17 at 10:19 a.m., an interview was conducted with LPN (licensed practical nurse) #4, a nurse who works regularly with Resident #13. When asked the process of conducting skin	F 282		

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assessments, LPN #4 stated that skin assessments were conducted weekly when the CNA (certified nursing assistant) gives the resident a shower. LPN #4 stated that the CNA will write any new skin areas on a CNA skin assessment sheet, or will document that no new areas were found. LPN #4 stated that she will sign the sheet after the CNA completes the sheet. When asked what her signature signifies, LPN #4 stated that her signature signifies that she has assessed the resident when the CNA alerts her of a new skin area. LPN #4 stated that she will go in and physically look at the new skin area. LPN #4 stated that she will not look at the resident if the CNA documents that no new areas were identified on the sheet. LPN #4 stated that the Unit manager will also sign the skin sheet but will not look at resident unless a new area is identified. When asked if nursing does their own skin assessment separate from the CNA's shower assessment, LPN #4 stated that if a new area is found, she will do her own assessment. When asked about the process followed when a new area is identified by the CNA, LPN #4 stated that she would refer the resident to the treatment nurse if she is in the building. LPN #4 stated that if the treatment nurse is not in the building, herself or the unit manager will assess the area and measure. LPN #4 stated that she was off when the sacral areas were identified to Resident #13. LPN #4 stated that when she returned to the facility the following week, Resident #13 was at the hospital. When asked if she was ever made aware or noticed any new skin areas to Resident #13 prior to 2/4/17, LPN #4 stated that she was not aware of any new skin areas or pressure sores and she did not notice any skin areas to Resident #13. LPN #4 stated that the nurse who identified the sacral areas on 2/4/17

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no longer worked for the facility. The nurse who found the sacral areas could not be reached for an interview.

On 2/27/17 at 2:12 p.m., an interview was conducted with CNA #23, a CNA who used to regularly work with Resident #13. When asked how often CNAs check the resident's skin, CNA #23 stated, "Every day when providing care. If there is a new area we will notify the charge nurse or treatment nurse if she is on the unit. Nursing would take it from there." CNA #23 stated that she hadn't worked with Resident #13 when his sacral areas were found. She could not recall if Resident #13 had any current sacral areas.

On 2/28/17 at 2:09 p.m., an interview was conducted with CNA (certified nursing assistant) #18, a CNA who works regularly with Resident #13. When asked when CNA's look at the resident's skin, CNA #18 stated, "Basically every day with bed baths and showers. If there are any changes in the skin we report this to the charge nurse or treatment nurse." CNA #18 stated that the nurse would look at the resident's skin after the CNAs alert them of a new condition. When asked if she ever saw Resident #13's skin prior to him going out to the hospital in early February, CNA #18 stated that she was not informed the resident had any skin issues until he came back from the hospital.

On 2/28/17 at 3:38 p.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing) and ASM #5, the previous DON. When asked the process for conducting skin assessments, ASM #2 stated that CNAs would check the skin during

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a bath and if a new area is found, the CNAs would alert the nurses. ASM #2 stated that the nurse would come in to evaluate the new area. ASM #2 stated that most of the time, the nurses are dependent on the CNAs to look at the skin. When asked what type of education the CNAs have to assess the residents' skin, ASM #2 stated that the CNAs definitely know if something is different on the resident and to alert the nurse. When asked if a CNA would be able to determine any area of redness, ASM #2 stated they she was confident the CNAs could determine areas of redness. When asked if a CNA was qualified to conduct a skin assessment, ASM #2 stated that the CNAs were not qualified and the nurses should be assessing the skin if a new area is identified and reported. When asked if nursing should be conducting skin assessment in addition to the CNAs doing body checks during showers or care, ASM #2 stated, "Nurses should be checking each resident, every shift." ASM #5 stated that 11-7 nurses used to be assigned residents to do weekly skin assessments.

On 2/28/17 at approximately 4:50 p.m., ASM #5 presented a skin integrity policy. When asked when the nurses conduct skin assessments, ASM #5 stated, "Daily. They aren't doing them. That's a problem."

On 2/28/17 at 3:38 p.m., ASM (administrative staff member) #2, the DON (Director or Nursing) and ASM #5, the previous DON were made aware of the above concerns.

Review of a CNA inservice completed on 12/20/16 documented the following: 1. Topics to be discussed: Repositioning and skin assessments 2. Pressure Ulcer Prevention and 3.

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Differentiate between bunny boots and pressure relief boots...Method of discussion: Hand out and discussion. Review of the signature sheets for this inservice revealed that only 14 out of 51 employed CNAs signed that they attended or understood the inservice.

The facility policy titled, "Skin Integrity," documents in part, the following: "Standard: The skin integrity of resident is preserved through adequate nutrition and hydration, daily inspection of the skin, compliance with proper body alignment and positioning and maintenance of maximum mobility. Policy: Residents who have suffered loss of skin integrity receive appropriate treatment. Residents with any broken skin problems are seen by a physician and/or the treatment control nurse. Procedures: 1. Licensed nurse: a. inspects the areas for potential breakdown on a daily basis. b. assess for mobility level, hydration-nutrition status, and presence of irritants, such as tight clothing or topical substances...Follow standards, policies, and procedures for pressure sores..."

Review of the facility's Job Description for the Charge Nurse, documents in part, the following: "Job Summary: A. Provides prescribed medical treatment and personal care services to the residents. B. Administration of all medications in accordance with policies and procedures. C. Assists with clinical staff development of non-professional employees...Responsibilities...E. Observe and assess residents on a daily basis."

Review of the facility's Job Description for the CNA, documents in part, the following: "Summary of Job Description: Caring for residents in a manner conducive to their safety and comfort

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F 282	Continued From page 56 according to policies and procedure as directed by licensed personnel... Responsibilities...H. Do treatments such as soaks, preventive skin care, ambulating residents etc. and chart." Assessments of the resident were not part of the CNA job description. No further information was presented prior to exit. [1] Metabolic encephalopathy-Encephalopathy is a term for any diffuse disease of the brain that alters brain function or structure. Encephalopathy may be caused by infectious agent (bacteria, virus, or prion), metabolic or mitochondrial dysfunction, brain tumor or increased pressure in the skull, prolonged exposure to toxic elements (including solvents, drugs, radiation, paints, industrial chemicals, and certain metals), chronic progressive trauma, poor nutrition, or lack of oxygen or blood flow to the brain. The hallmark of encephalopathy is an altered mental state. This information was obtained from The National Institutes of Health. https://www.ninds.nih.gov/Disorders/All-Disorders/Encephalopathy-Information-Page.. [2] Stage IV Pressure Ulcer- Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. This information was obtained from the National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm. 4.a. The facility staff failed to follow the written plan of care for the administration of oxygen for Resident #4. Resident #4 was admitted to the facility on	F 282		

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F 282	Continued From page 57 6/13/13 and most recently readmitted on 5/2/16 with diagnoses including, but not limited to: heart disease, breast cancer, diabetes, and high blood pressure. On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 1/22/17, Resident #4 was coded as being severely cognitively impaired for making daily decisions. She was coded as having received oxygen during the look back period. On the following dates and times, Resident #4 was observed lying in her bed with oxygen flowing through a nasal cannula (1) at the rate of 3 lpm (three liters per minute): 2/21/17 at 4:35 p.m.; 2/22/17 at 7:45 am; 2/22/17 at 10:05 a.m.; and 2/22/17 at 3:55 p.m. A review of the physician's orders for Resident #4 revealed the following order written on 7/17/16 and electronically signed by the physician: "O2 (oxygen) continuously running 2L/min (two liters per minute) via (by way of) NC (nasal cannula) r/t (related to) SOB (shortness of breath) and comfort measures every shift." A review of Resident #4's comprehensive care plan dated 1/24/17 revealed, in part, the following: "Resident continues to decline; resident appears to be at the end of life...Oxygen per order." On 2/23/17 at 11:35 a.m., LPN (licensed practical nurse) #5 was interviewed. LPN #5 was asked about the process for following the physician's order for oxygen administration to a resident. LPN #5 stated: "You visualize it. I try to do it when I first see a resident." She stated if a resident is on continuous oxygen by way of an oxygen concentrator, she may not look as closely	F 282		

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at it as she would look at a portable oxygen tank. LPN #5 stated: "No one is supposed to be fiddling with the concentrator." She stated most orders for oxygen are at two liters per minute. When asked how she would verify whether or not a rate on a concentrator is correct, LPN #5 stated: "There's an order. It's also on the TAR (treatment administration record) to be signed off." When asked if oxygen rate is a part of a resident's care plan, LPN #5 stated: "Yes, I believe it is." When asked if the plan of care is to be followed by all staff, LPN #5 stated: "Yes."

On 2/23/17 at 4:40 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of the above concern.

No further information was provided prior to exit.

(1) "Oxygen therapy may help you function better and be more active. Oxygen is supplied in a metal cylinder or other container. It flows through a tube and is delivered to your lungs in one of the following ways...Through a nasal cannula, which consists of two small plastic tubes, or prongs, that are placed in both nostrils." This information is taken from the website http://www.nhlbi.nih.gov/health/health-topics/topics/oxt.

According to Fundamentals of Nursing, Perry and Potter, 6th edition, Mosby, page 278; "The nurse applies the nursing process to provide appropriate and effective nursing care. The process begins with an assessment or gathering and analysis of information about the client's health status. The nurse then makes clinical

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F 282	Continued From page 59 judgments about the client's response to health problems, defined as nursing diagnoses. Once the nurse defines appropriate nursing diagnoses, a plan of care is developed. The plan includes interventions individualized to each of the client's nursing diagnoses. The nurse performs all planned interventions in an effort to improve or maintain the client's health. After administering interventions, the nurse evaluates the client's response and whether the interventions were effective." b. The facility staff failed to ensure that weekly skin assessments were performed by qualified individuals for Resident #4. CNAs performed the weekly skin assessments. On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 1/22/17, Resident #4 was coded as being severely cognitively impaired for making daily decisions. She was coded as being completely dependent on two staff members for bed mobility and transfers. She was coded as always being incontinent of both bowel and bladder. She was coded as having one stage 3 pressure ulcer that was not present at the time of her most recent admission. On the quarterly MDS with an assessment reference date of 10/22/16, Resident #4 was coded as being moderately cognitively impaired for making daily decisions. She was coded as being completely dependent on two staff members for bed mobility, and as requiring the extensive assistance of two staff members for transfers. She was coded as being frequently	F 282		

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incontinent of both bowel and bladder. She was coded as having one stage 2 pressure ulcer (9), with an origin date of 10/17/16.

On 2/22/17 at 10:05 a.m., observation was made of Resident #4 as she received a dressing change on her sacral pressure ulcer by LPN (license practical nurse) #1, the wound nurse. At the time of the observation, the wound measured approximately 8 X 9 X 1 cm (centimeters), and was described by LPN #1 as "a stage 4 (3)." The wound bed contained approximately 20% pink granulation tissue (4) and approximately 80% dead tissue. LPN #1 stated that she is the wound nurse for all the residents in the facility.

A review of the physician's orders revealed the following order, dated and electronically signed by the physician on 10/17/16: "Cleanse open area to left buttock with DWC (dermal wound cleanser). Apply Santyl and dry dressing QD (every day) and prn (as needed)." This order was discontinued 11/16/16. A review of the TAR (treatment administration record) for October 2016 revealed this treatment was applied as ordered.

A review of the clinical record revealed a quarterly nursing assessment completed by LPN #1 on 10/19/16. On this assessment, the resident was documented, by way of a check-off item on the assessment, to have a Stage 2 pressure ulcer. This assessment contained no description, size or further narrative information for this wound.

A review of nursing shift reports dated 11/1/16, 11/2/16, and 11/3/16 and signed by LPN #4 revealed, by way of check-off items on the assessments, that Resident #4 had a Stage 2

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pressure ulcer. Theses assessments contained no description, size or further narrative information for this wound.

A review of the weekly CNA (certified nursing assistant) skin assessment dated 11/17/16 for Resident #4 revealed three initials in a box beside the instructions: "Initial here if no abnormalities seen." The CNA whose initials were in the box was not available for interview.

A review of the physician's orders for Resident #4 revealed the following order, dated and signed on 11/16/16: "Cleanse open area to left buttock with Normal Saline (5). Apply Santyl (6) and dry dressing QD (every day) and prn (as needed) until healed." This order was documented as discontinued on 12/16/16.

A review of the TARs (treatment administration records) for November and December 2016 revealed this treatment was completed as ordered.

Further review of the clinical record revealed no evidence of nurses' notes or wound assessments of Resident #4's buttocks area for 11/16/16.

A review of the weekly CNA (certified nursing assistant) skin assessment dated 12/13/16 for Resident #4 revealed three initials in a box beside the instructions: "Initial here if no abnormalities seen."

A review of the physician's orders for Resident #4 revealed the following order, dated and signed on 12/16/16: Cleanse open area to sacral fold with 1/4 str. (one-quarter strength) Dakins solution (7).

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F 282	Continued From page 62 Skin prep (8) peri wound (skin around the wound). Apply Santyl and dry dressing QD and prn until healed." This order was documented discontinued on 1/19/17. A review of the TARs for December 2016 and January 2017 revealed this treatment was completed as ordered. Further review of the clinical record revealed no evidence of nurses' notes or wound assessments to include meaurements and staging of Resident #4's buttocks area for 12/16/16. Further review of the clinical record revealed a document titled "Non-Pressure Skin Condition Report" dated 12/21/16, completed by LPN # 1. The document contained the following entries: - "Site/Location (Indicate on body form): sacrum - Condition is: Other - shear - Size in cm (centimeters): 1.8 X 5 X .01 - Exudate (drainage) type: Serous (clear) - Exudate amount: scant - Wound bed: Pink/Beefy red - Progress: Not changed - Treatment: Continue - Comments: Two separate areas, grouped together in measurement." Further review of the clinical record revealed a document titled "Non-Pressure Skin Condition Report" dated 12/28/16, completed by LPN # 1. The document contained the following entries: - "Site/Location (Indicate on body form): sacrum - Condition is: Other - shear - Size in cm (centimeters): 2.4 X 5 X .01 - Exudate (drainage) type: Serous (clear) - Exudate amount: scant - Wound bed: Pink/Beefy red	F 282		

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F 282	Continued From page 63 - Progress: Deteriorated - Treatment: Continue - Comments: Two separate areas, grouped together in measurement." Further review of the clinical record revealed no further documentation regarding the open area on Resident #4's sacrum between 12/28/16 and 1/5/17. A review of the weekly CNA (certified nursing assistant) skin assessment dated 1/4/17 for Resident #4 revealed three initials in a box beside the instructions: "Initial here if no abnormalities seen." Further review of the clinical record revealed a document titled "Wound Care Specialist Evaluation" dated 1/5/17 and signed by ASM (administrative staff member) #4 on 1/5/17, the wound doctor. The document contained the following: "Chief Complaint: Patient has a wound on their sacrum...At the request of [name of primary care physician], this 101 year old female was seen and evaluated today. She presents with a stage 3 pressure wound of the medial sacrum of at least 1 day(s) in duration. There is light serous exudate. There is no indication of pain associated with this condition...Stage 3 Pressure Wound of the Medial Sacrum Focused Wound Exam...Etiology (Quality): Pressure, MDS 3.0 Stage 3, Duration > 1 (greater than one) days, Objective: Healing, Manage Pain, Wound Size (LXWXD): 4.2 X 4.9 X 0.1 cm, Surface Area 20.58 cm [squared], Cluster Wound, Exudate: Light Serous, Yellow Necrotic: 55%, Granulation Tissue: 10%, Skin: 35%, 1/5 (1/5/17) wound over old scar tissue, Dressing: Santyl - once daily, dry protective dressing - once daily."	F 282		

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F 282	Continued From page 64 A review of Resident #4's comprehensive care plan dated 11/3/16 and most recently updated on 1/19/17 revealed, in part, the following: "Category: ADL (activities of daily living) Functional/Rehabilitation Potential: Continues to decline overall; extensive to total assist of one or two with ADLS, transfers and bed mobility; provide comfort care measures. Category: Pressure Ulcer. Overall decline; Potential for pressure ulcers, bruising, skin tears, diabetic and circulatory skin issues as well; preventive tx (treatment) to sacrum and btw (between) toes. 12/16 - see Tx order [change]; open areas to sacral fold. See tx order. 1/18 area to sacrum stage III; 1/19 cont. to have area to sacrum - cont (continue) to decline...Approach (all approaches dated 11/3/16): Assess resident for presence of risk factors. Treat, reduce, eliminate risk factors to extent possible. Assist in turning and repositioning routinely. Conduct a systematic skin inspection routinely. Pay particular attention to the bony prominences. Diet as ordered. Encourage fluids. Encourage physical activity, mobility, and range of motion to maximal potential. Minimize skin exposure to moisture. Monitor and report labs (laboratory tests) as ordered. Provide incontinence care after each incontinent episode. Report any signs of skin breakdown (sore, tender, red, or broken areas). Supplements/vitamins as ordered. Take special care when assisting in care in attempts to reduce skin tears and bruising. Treatments per order; refer to wound md (doctor) as indicated. Use incontinent products to maintain personal hygiene and dignity. Use moisture barrier product to perineal area. 1/18 - See new tx order. 1/20 - air mattress per order."	F 282		

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F 282	Continued From page 65 On 2/23/17 at 12:45 p.m., LPN #1, the wound nurse was interviewed regarding Resident #4's sacral wounds. She reviewed the 12/21/16 and 12/28/16 Non Pressure Skin Condition Reports and stated: "There were two separate places. Then one healed up. And the other one opened up." When asked to provide the surveyor with documentation regarding the size, stage and condition of these wounds which precipitated the 11/16/16 and 12/16/16 orders, she stated she was not sure if any documentation existed, and that she would search for it. On 2/23/17 at 3:05 p.m., LPN #1 was interviewed again regarding Resident #4's sacral wounds. LPN #1stated: "The wound doctor saw her back in late summer (2016) for open areas on her sacrum and buttocks. But he stopped seeing her in early September. I think that area had healed. On 11/16/16, we started cleaning an open area with normal saline and applying Santyl." She stated that as best she remembered, there was only one open area being treated at that time. When asked to provide the documentation regarding the size, stage and condition of this area to which she was applying a debridement agent, LPN #1 stated: "There is no documentation as to why." When asked what the wound looked like, she stated she could not recall. When asked to provide skin assessments between 11/16/16 and 12/16/16 (when the treatment was changed), LPN #1 stated: "There is no documentation." LPN #1 stated: "On 12/16/16, the order was changed to use the Dakins solution for cleansing the wound." When asked to provide documentation as to why the treatment needed to be changed, LPN #1 stated: "There is no documentation as to why." When asked why Dakins would be used instead of	F 282		

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normal saline, LPN #1 stated: "You would use Dakins if you needed a cleanser that would fight against bacteria because Dakins kills bacteria." She stated she thought that by 12/16/16, Resident #4 had two open areas on her sacrum. She stated she could not locate any documentation to verify what she remembered. When asked if she remembered anything about the open areas from doing the daily treatments, LPN #1 stated: "I did not think they were pressure. Not at that time, but [ASM #4] told me it was pressure. He said it wasn't shearing, like I had in my notes. I was wrong about that." When asked the process for identifying, staging, assessing and monitoring a pressure area, she stated there should be weekly skin assessments, with measurements and staging. She stated she would ordinarily write a progress note to accompany the weekly assessments. When asked about the process for referring a resident to the wound specialist, LPN #1stated: "If the wound is clean and is a stage 2 or less, we will do a standard treatment. But if the wound starts with necrosis or getting any kind of overlay, we will start using the Santyl. [ASM #4] gets called in if I'm using Santyl." When asked why ASM #4 was not called until 1/5/17 when the Santyl treatment began on 11/16/16, LPN #1 stated: "I'm not sure. [ASM #4] may have been on vacation then." LPN #1 stated: "This was my fault. I should have been measuring it and documenting assessments all along. I should have had weekly measurements, and I should have notified the PCP (primary care physician) about what was going on. I know I should have been doing more."

On 2/23/17 at 4:10 p.m., ASM #4 was interviewed. When asked if he remembered

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seeing Resident #4 in August or September of 2016, he stated he did not remember seeing her at that time. When asked if he remembered seeing the wound on 1/5/17, ASM #4 stated: "No, I don't have a memory of seeing it." He stated his note indicates the scar tissue Resident #4 had from a previous wound broke down and reopened to create the wound he staged at Stage 3 on 1/5/17. When asked if he had been aware that Resident #4 had been treated with Santyl prior to his seeing the wound on 1/5/17, he stated he was not aware. When asked to speak to the avoidability of Resident #4's pressure ulcer, ASM #4 stated: "I guess you could make a case that nothing is truly, purely unavoidable. However, this lady is old. It is not an excuse. But she is old and debilitated. Even at six months out from a wound, scar tissue is only 60% strength of regular skin. She was more likely than not going to have skin failure."

On 2/23/17 at 4:25 p.m., ASM #2, the director of nursing was interviewed regarding the skin assessment process at the facility. She stated the CNAs are supposed to do weekly skin assessments, usually coinciding with a resident's shower. She stated if a resident has a pressure area or other type of wound, a staff member, usually the wound nurse, should be assessing and documenting on the wound weekly.

On 2/23/17 at 4:40 p.m., ASM #1, the administrator, and ASM #2 were informed of these concerns.

On 2/27/17 at 10:00 a.m., RN (registered nurse) #5, a unit manager, was interviewed. When asked about her signatures on the above-referenced CNA skin assessment sheets

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(11/17/16 and 12/13/16), RN #5stated: "To my knowledge, I didn't document anything myself. I didn't directly chart. I may have seen [Resident #4] once with [ASM #4]." She stated that the floor nurses and wound nurse were responsible for reporting the skin issues. She stated Resident #4 was declining medically. When asked about her role with skin assessments and wounds, she stated she intervenes if there is a need to facilitate action from the wound nurse and/or the floor nurse. She stated she thought that the wound nurse was aware of and "handling" Resident #4's skin issues. She stated unit managers may perform wound care if it is not done by either the wound nurse or the floor nurse. She stated she would not necessarily document on the wound unless she performed the wound care herself. She stated wound care documentation should include appearance, measurements, and a description of drainage.

On 2/27/17 at 10:10 a.m., LPN #4, a floor nurse who signed the 11/17/16 CNA skin assessment sheet, was interviewed. She stated the CNA completes the skin assessment when the resident receives a shower. The CNA documents the findings on a skin a sheet of paper with the outline of a body on it. She stated the floor nurse and unit manager sign off on the sheet. When asked what her signature on the 11/17/16 means, she stated her signature signifies that she has assessed the resident; if there is a problem area, that she has looked at the area and initiated a treatment. She stated Resident #4 had a pressure ulcer on her sacrum, and that she had indicated this on the 11/3/16 CNA weekly skin assessment sheet. She stated she thought Resident #4 was receiving treatments for the pressure ulcer, but that she did not remember the

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stage. She stated that there is a place on the weekly assessment sheets for the CNA to state that there are no new areas noted. This is the box where the CNA puts her/his initials. She stated the floor nurse and unit manager also sign off on this. She stated if there was no indication of new areas, she would not go and look at the resident.

On 2/27/17 at 3:25 p.m., CNA #8 was interviewed regarding skin assessments. CNA #8 stated: "When we give the showers we make sure there is nothing new and that old areas are healing. We look at the skin." CNA #8 was asked if anyone else was doing assessments of residents' skin. CNA #8 stated: "The aides are primarily doing the skin assessments, documenting on the skin assessment sheets. The nurses do a skin assessment on admission. If I haven't seen someone (a resident) for a couple of days and see something, I'll ask the nurse if it's something new." When asked about the education she had received in regards to performing and documenting skin assessments, CNA #8 she stated: "We have had in-services for skin assessments and wound care. We haven't had any specific education about the skin assessments, just documenting on the skin assessment sheet."

On 2/28/17 at 9:20 a.m., LPN #16 was interviewed. She stated her signature on the CNA weekly skin assessment means that the CNA has looked at the skin head to toe and has found no skin issues. She stated that she looks at the resident's skin no matter what the CNA states. She stated her signature also indicates that she concurs with what the CNA states. When asked about her signature on the 12/13/16

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CNA weekly skin assessment sheet meant, LPN #16 stated: "That is too far back for me to remember."

On 2/28/17 at 4:00 p.m., ASM #2 was interviewed. When asked who is responsible for skin assessments and wound care, she stated the wound care nurse is responsible for any wounds. When asked who is responsible for the routine skin assessments, ASM #2 stated: "They are performed by the nurse on admission and then prn (as needed). The CNAs do the weekly skin assessments." When asked to clarify who is responsible for the weekly skin assessments, she stated the CNAs perform the skin assessments at the time of the weekly shower, document any abnormalities, and notify the nurses. When asked the process for the nurse to perform a skin assessment, she stated: "On admission, quarterly, and if the CNA states there is a problem." When asked which staff members are qualified to perform skin assessments, she responded: "The nurse." When asked if a CNA is qualified under training and scope of practice to perform skin assessments, ASM #2 stated: "No." When asked about training provided to CNAs regarding routine skin assessments, ASM #2 stated: "CNAs know the residents, and usually the same CNA does [the residents"] showers each week. The CNAs are not trained to do skin assessments."

During the survey Resident #4's Braden Scale assessments were requested and not provided.

A review of the facility policy entitled "Skin Integrity" revealed, in part, the following: "Policy: To promote a systematic approach and monitoring process for residents with pressure

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reassessed. Re-evaluation of the treatment plan including determining whether to continue or modify current interventions is also indicated...The Unit Manager, along with the Multidisciplinary Care Plan Team, if deciding to retain the current regimen will document the rational (sic) for continuing the present treatment."

A review of a separate policy entitled "Skin Integrity" revealed, in part, the following: "STANDARD: The skin integrity of resident is preserved through adequate nutrition and hydration, daily inspection of the skin, compliance with proper body alignment and positioning, and maintenance of maximum mobility. POLICY: Residents who have suffered loss of skin integrity receive appropriate treatment. Residents with any broken skin problems are seen by a physician and/or the treatment nurse. PROCEDURES: Licensed nurse: inspects areas for potential breakdown on a daily basis...The licensed nurse implements a program of...documentation (sic) the condition of areas being treated once a week that includes size, depth, drainage, healing, medication, and devices used to reduce pressure...Follow standards, policies, and procedures for pressure sores."

(1) The NPUAP (National Pressure Ulcer Advisory Panel) defines a pressure ulcer as a "...localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction." This information is taken from Pressure Ulcer Staging Revised by NPUAP. Copyright 2007. National Pressure Ulcer Advisory Panel. 8/3/2009

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F 282	Continued From page 73 http://www.npuap.org.pr2.htm. (2) Stage 3 - Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. This information was obtained from the website http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagescategories/. (3) Stage 4 - Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. This information was obtained from the website https://www.npuap.org/national-pressure-ulcer-advisory-panel-npuap-announces-a-change-in-terminology-from-pressure-ulcer-to-pressure-injury-and-updates-the-stages-of-pressure-injury/. (4) Granulation - "Red, moist tissue is indicative of granulation tissue, which is progressing toward healing." Potter and Perry, Fundamentals of Nursing, Sixth edition, page 1487. (5) Normal saline is "A sterile, nonpyrogenic solution of electrolytes in water for injection intended only for sterile irrigation, rinsing, dilution and cell washing purposes." This information is taken from the website https://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archiveid=2363.	F 282		

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F 282	Continued From page 74 (6) Santyl - "Collagenase Santyl® Ointment is a sterile enzymatic debriding ointment which contains 250 collagenase units per gram of white petrolatum USP. The enzyme collagenase is derived from the fermentation by Clostridium histolyticum. It possesses the unique ability to digest collagen in necrotic tissue." This information is taken from the website https://dailymed.nlm.nih.gov/dailymed/druglnfo.cfm?setid=a7bf0341-49ff-4338-a339-679a3f3f953d . (7) Dakins - Used to "prevent and treat infections of the skin and tissue. Pre and post surgery. Cuts, abrasions and skin ulcers." This information is taken from the website https://dailymed.nlm.nih.gov/dailymed/druglnfo.cfm?setid=a0ee103e-1f9c-4ffb-aafe-bb49d30f7816 . (8) "Sureprep® is a fast drying skin protectant. Vapor permeable and delivers protection from friction and incontinence. The transparent barrier may be used on periwound, peristomal or areas that come in contact with bodily fluids." This information is taken from the manufacturer's website https://www.medline.com/product/Sureprep-Skin-Protectant-Wipe/Liquid-Bandages/Z05-PF00058. (9) Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result	F 282		

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F 282	Continued From page 75 from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions). This information is taken from the website <http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ >	F 282		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and	F 309	1. The licensed nursing staff assigned to Resident #6 have been instructed to attempt non-pharmacological intervention before giivng Norco and to document these measures in the progress notes. The care plan has been revised to included non pharmacologic intervention. The licensed nursing staff assigned to resident #7 have been instructed to check for the lateral positioning device before documenting that the device is in place. 2. A 100% audit of PRN medications and chart docuemtnion for non pharmalogical interventions has been completed by the ADON and unit managers. The positioning devices were also audited at this time. 3.All licensed staff has been educated on the use of the non pharmalogical interventions and documentations prior to adminstering a PRN medications by DON or designee The restorative nurse and C.N.A's have been delegated the responsibility of appling all positional devices. The licensed nurse is still responsbile for assuring placement and	03/1/17 03/22/17 03/29/17

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F 309	Continued From page 76 preferences. This REQUIREMENT is not met as evidenced by: Based staff failed to provide necessary care and services to attain or maintain the highest level of well-being for two of 26 residents in the survey sample, Resident #6 and #7. 1. For Resident #6, facility staff failed to provide non-pharmacological interventions prior to the administration of Norco [1] 5/325 mg (milligrams) on several occasions in January and February of 2017. 2. The facility staff failed to implement physician ordered left lateral side support for Resident #7 while in the wheelchair. The findings include: 1. For Resident #6, facility staff failed to provide non-pharmacological interventions prior to the administration of Norco [1] 5/325 mg (milligrams) on several occasions in January and February of 2017. Resident #6 was admitted to the facility on 6/28/13 and readmitted on 1/5/17 with diagnoses that included but were not limited to high cholesterol, CVA (stroke), seizure disorder, aphasia [2], Multiple Sclerosis [3] and altered mental status. Resident #6's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/8/16. Resident #6 was coded as being cognitively impaired in the ability to make daily decisions scoring 04 out of 15 on the BIMS (Brief interview for mental status) exam. Resident #6	F 309	cont... signing the treatment sheet. 4. PRN medication usage and positional devices will be reviewed for documentation weekly in the risk managment meeting. The QA committee will monitor.	03/22/17

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F 309	Continued From page 77 was coded as requiring extensive assistance with transfers, dressing, and eating, and total dependence on staff with bathing. Review of the most recently signed physician order sheet documented the following order: "Norco 5/325 mg (milligrams) 1 tab (tablet) po (by mouth) TID (Three times day) prn (as needed) for pain." This order was initiated on 01/05/17. Review of Resident #6's January 2017 MAR (Medication Administration Record) revealed the following order: "Norco (hydrocodone-acetaminophen)-Schedule II tablet; 5/325 mg; Amount to Administer: 1 tablet; oral. Three Times a Day -PRN (as needed)." Norco was documented as administered on 1/28/17 at 8:10 p.m., and 1/29/17 at 7:27 p.m. Under "Reasons/Comments" the following was documented: "1/28/17 8:10 p.m., PRN Reason: Pain, Comment: given at 3:45 p.m. pain moaning unale (sic) to rate. 1/29/17 7:27 p.m., PRN Reason: Pain, Comment: moaning unable to rate." Non-pharmacological documented interventions could not be found in the nursing notes prior to the administration of the PRN Norco on 1/28/17. Review of Resident #6's February 2017 MAR revealed that Norco was administered to Resident #6 on 2/1/17 at 7:34 p.m., 2/4/17 at 8:07 p.m., 2/10/17 at 8:18 p.m., and 2/18/17 at 7:17 p.m. Under "Reasons/Comments" the following was documented: "2/01/17 7:34 p.m., PRN Reason: Pain,	F 309		

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F 309	Continued From page 78 Comment: moaning unable to rate. 2/04/17 8:07 p.m., PRN Reason: Pain, Comment: moaning unable to rate. 2/10/17 8:18 p.m., PRN Reason: Pain, Comment: moaning, unable to rate. 2/18/17 at 7:17 p.m., PRN Reason: Pain, Comment: moaning unable to rate." Non-pharmacological documented interventions could not be found in the nursing notes prior to the administration of the PRN Norco on 2/1/17, 2/4/17, 2/10/17 and 2/18/17. Review of Resident #6's Pain care plan dated 9/20/16 and updated on 11/7/16, did not address attempting non-pharmacological interventions prior to the administration of Norco. On 2/27/17 at 10:19 p.m., an interview was conducted with LPN (licensed practical nurse) #4. When asked about the process of administering prn pain medication, LPN #4 stated that nursing should try any non-pharmacological intervention such as moving the resident to a quieter room, reposition, etc. When asked if non-pharmacological interventions attempted should be documented, LPN #4 stated, that non-pharmacological interventions should be documented. When asked where non-pharmacological interventions are documented, LPN #4 stated, "In the nursing notes." When asked if she could identify the only nurse who administered the pain medication for the above dates, LPN #4 looked at the MAR (medication administration record) and stated, "This is (Name of LPN #16)." LPN #16 could not be reached for an interview due to an emergent situation.	F 309		

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F 309	Continued From page 79 On 2/27/17 at 9:06 a.m., an interview was conducted with LPN #2, the unit manager. When asked about the process of administering prn pain medication, LPN #2 stated that she would first find out the resident's pain level. LPN #2 would then attempt non-pharmacological interventions prior to administering pain medication. When asked if non-pharmacological interventions should be documented in the clinical record, LPN #2 stated, "Should be." When asked what it meant, if there were no non-pharmacological interventions documented and pain medication was administered, LPN #2 stated, "I would assume the nurse didn't do it (non- pharmacological interventions)." On 2/27/17 at 5:50 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. Facility policy titled, "Daily Pain Assessment," documents in part, the following: "Management of Residents who have Complaints of Pain...1. On a scale of 1-10 with 10 being the worst pain experienced and 1 the least, how do you rate your pain? 2. What makes your pain better?, 3. Offer alternatives to medication, such as, relaxation, returning to bed, warm compress, repositioning etc. 4. Medicate if there are no other alternatives to that will help the resident. 5. If the resident is unable to relate a number for his/her pain rating, observe the resident's demeanor and facial expression. 6. Use the facial expression scale at the bottom of this sheet. 7. Of the resident is alert and can relate information, ask what increases the pain and what decreases the pain. 8. Ask what kind of pain it is, shooting,	F 309		

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F 309	Continued From page 80	F 309		

aching, burning, pricking, pulling, sharp, throbbing, dull, etc. 9. Observe how pain effects (sic.) the resident's quality of life. Document all of this information in the chart. 10. Reassess pain in 30-60 minutes after giving medication and document effectiveness using the above mentioned scales.

No further information was presented prior to exit.

[1]-Hydrocodone and acetaminophen combination used to treat moderate to severe pain. This information was obtained from the National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010590/?report=details.

[2]-Aphasia is a disorder caused by damage to the parts of the brain that control language. It can make it hard for you to read, write, and say what you mean to say. It is most common in adults who have had a stroke. Brain tumors, infections, injuries, and dementia can also cause it. This information was obtained from the National Institutes of Health. https://medlineplus.gov/aphasia.html.

[3]- Multiple sclerosis (MS) is a nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS. This information was obtained from The National Institutes of Health. https://medlineplus.gov/multiplesclerosis.html.

2. The facility staff failed to implement physician

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F 309	Continued From page 81 ordered left lateral side support for Resident #7 while in the wheelchair. Resident #7 was admitted to the facility on 6/23/14 and readmitted to the facility on 6/18/15. Resident #7's diagnoses included but were not limited to: dementia with lewy bodies (1), Parkinson's disease (2), generalized anxiety disorder and history of falling. Resident #7's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/24/16, coded the resident as being severely cognitively impaired, scoring a three out of a possible 15 on the brief interview for mental status. Section G coded the resident as requiring extensive assistance of two or more staff with bed mobility, transfers and walking in the corridor. Review of Resident #7's clinical record revealed a physician's order summary signed by the physician on 1/13/17 that documented an order for the resident to have left lateral side support at all times while up in the wheelchair. Resident #7's comprehensive care plan with a problem start date of 1/6/17 documented, "HIGH FALL RISK R/T (related to) CONFUSION; COMBATIVE BEHAVIOR; INCREASED ANXIETY; PSYCHOTROPIC MEDS (medications); VISION LOSS; SEVERAL FALLS SINCE ADMIT...Approach: LEFT LATERAL SIDE SUPPORT AT ALL TIMES WHILE UP IN W/C (Wheelchair)..." On 2/22/17 at 9:25 a.m. and 12:40 p.m., Resident #7 was observed in a high back wheelchair in the day room. No left lateral support positioning device was observed in the resident's wheelchair. The resident's elbow was wedged against the	F 309		

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F 309	Continued From page 82 back of the wheelchair and the arm rest. On 2/22/17 at 3:44 p.m., an interview was conducted with RN (registered nurse) #5. RN #5 was asked how nursing staff was made aware of what type of positioning devices were required for each resident. RN #5 stated nurses should see orders for the devices in the physician's orders and on the treatment administration record. RN #5 stated the nurses should pass that information on to CNAs during report to make sure the positioning devices are in place. On 2/22/17 at 4:50 p.m., an interview was conducted with CNA (certified nursing assistant) #3 (the CNA caring for Resident #7). CNA #3 was asked how she was made aware of what type of positioning devices were required for each resident. CNA #3 stated usually she knows but could ask the nurse if she had a question. CNA #3 stated the therapy department in-services staff when a new positioning device is implemented. CNA #3 was asked if Resident #7 was supposed to have any positioning devices. CNA #3 stated at one point in time the resident had a "side piece" that was positioned down in the resident's wheelchair to aid with positioning because the resident leaned to the side. CNA #3 confirmed the resident did not have the device placed in the wheelchair when she put him in the wheelchair and she didn't know what had happened to the device. On 2/27/17 at 5:50 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. The facility document titled, "Assistive Devices	F 309		

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F 309	Continued From page 83 For Positioning" documented, "Policy: Facility is to use the least restrictive device for positioning in high risk residents...Devices currently available are the following...Side padding for trunk alignment..." No further information was presented prior to exit. (1) "Lewy body disease is one of the most common causes of dementia in the elderly. Dementia is the loss of mental functions severe enough to affect normal activities and relationships. Lewy body disease happens when abnormal structures, called Lewy bodies, build up in areas of the brain..." This information was obtained from the website: https://medlineplus.gov/lewybodydisease.html (2) "Parkinson's disease (PD) is a type of movement disorder. It happens when nerve cells in the brain don't produce enough of a brain chemical called dopamine..." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=parkinson%27s+disease	F 309		
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent	F 314	1. Resident #13 has expired. Resident #4 is currently being followed weekly by the wound care MD. The treatment nurse is doing treatments as ordered and completing weekly assessments with measurements. When the treatment nurse is not in the facility, the charge nurse does the treatments. 2. All residents receiving wound care have been auduited by the DON or designee for approriate staging documentaiton and weekly measurements.	03/22/17 03/29/17

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F 314	Continued From page 84 pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide the necessary treatment and services consistent with professional standards of practice, to promote healing of pressure ulcers for two of 26 residents in the survey sample, Residents #13 and #4. 1. The facility staff inaccurately identified a new sacral area on 2/4/17 as an abrasion that was determined to be and documented as a Stage III (three)* pressure ulcer** upon Resident #13's admission the emergency department on 2/5/17, resulting in harm. Also weekly skin assessments from a licensed nurse could not be provided prior to the inaccurately identified sacral area 2/4/17. 2. Resident #4 was documented as having a stage II pressure sore on the sacrum and as receiving treatments without any initial or ongoing wound measurements/assessments and on 1/5/17 the wound care physician identified a deterioration of the pressure sore status to a stage 3 (2) with yellow necrotic wound tissue.	F 314	3. The licensed nursing staff has been educated on wound staging and wound measurements. It is the responsibility of the nurse who admits or notes a wound on a resident to document the demensions of the wound, the cause, the stage if pressure also to notify the MD for a treatment and the RP. If the treatment nurse is on duty she is to be notified and it is her responsibility to follow up. The treatment nurse is receiving education by DON and Designee on staging, pressure, non pressure wounds, measuring wounds, and weekly assessments and documentation. 4. The unit manager on each unit will monitor wounds and documentation. The treatment nurse will report on wounds weekly at the risk management meeting and quarterly at the QA meeting.	03/29/17 03/22/17

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F 314	Continued From page 85 The findings include: 1. Resident #13 was admitted to the facility on 8/4/16 and readmitted on 2/14/17 with diagnoses that included but were not limited to metabolic encephalopathy [1], Pressure Ulcer Stage IV of the sacral region [2], Parkinson's disease, high blood pressure, prostate cancer, and dementia. Resident #13's most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 2/20/17. Resident #13 was coded as being severely impaired in the ability to make daily decisions scoring 03 on the Staff Interview for Mental Status Exam. Resident #13 was coded as requiring total dependence on one to two facility staff with transfers, bed mobility, locomotion on the unit, dressing, eating, personal hygiene and bathing. Resident #13's MDS assessment prior to 2/20/17, was a quarterly assessment with an ARD (assessment reference date) of 11/12/16. Section M. "Skin Conditions" of the MDS coded Resident #13 as being a risk of developing pressure ulcers. Section M2010. "Unhealed Pressure Ulcer(s)" documented the following: "Does the resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher? " A "0" (zero) was documented indicating Resident #13 had no pressure areas at that time. Review of Resident #13's clinical record revealed the following nursing note dated 2/4/17 at 3:05 a.m., "Resi (Resident) is A&O x 1 (alert and oriented to self). Resi is able to communicate some needs. Resi is resting in bed with eyes	F 314		

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F 314	Continued From page 86 closed at this time. Resp (Respirations) even and non-labored on RA (Room Air). HOB (Head of Bed) slightly elevated for comfort and to facilitate lung expansion. Resi continue to receive LTC (long term care) services r/t (related to) multiple Dx (diagnoses): to include prostate cancer, HTN (hypertension), dementia, high cholesterol and Parkinson's Disease. No s/sx (signs or symptoms) of distress or discomfort noted at this time. No c/o (complaints) pain voiced when questioned. Skin warm and dry to touch. Area noted to resident's sacrum and scrotum, resi positioned on side and note for treatment nurse to evaluate. Other treatments applied per MD (medical doctor) orders, resi tolerated well..." Review of a non-pressure skin condition report for Resident #13 documented the following: "Date First Observed: 2/4/17, Site/Location: Inner, upper, sacral fold. (Will have Dr. (Name of wound care doctor) eval (evaluate) 2/9/17. Condition is a..." A check mark was documented under "Abrasion" indicating that two of the areas were found to be abrasions. A check mark was also documented under "Old scar" indicating that one of the areas was an old scar. Further review of the non-pressure skin condition report for Resident #13 documented the following: "Date: 2/4/17, Size in cm (centimeters) 0.1 x 0.1 x 0, Exudate type: None, Exudate amount: None, Tunneling: 0, Undermining: 0, Wound Bed: Pink/Beefy red, Surrounding Skin Color: Normal for skin, Surrounding tissues/wound edges: Normal for skin. Culture sent: No, Progress: New, Treatment: Continue treatment, Comments: Top, Pin-point area sacral fold, Triad paste q (every) shift, Pinpoint area.	F 314		

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F 314	Continued From page 87 Date: 2/4/17, Size in cm (centimeters) 2.0 x 1.0 x 0, Exudate type: None, Exudate amount: None, Tunneling: blank, Undermining: blank, Wound Bed: black/brown, Surrounding Skin Color: Normal for skin, Surrounding tissues/wound edges: Normal for skin. Culture sent: No, Progress: New, Treatment: Continue treatment, Comments: Scar area to sacral fold, scar area-firm, not mushy or boggy. Triad paste q (every shift). Date: 2/4/17, Size in cm (centimeters) 0.6 x 0.3 x .1, Exudate type: None, Exudate amount: None, Tunneling: 0, Undermining: 0, Wound Bed: Pink/Beefy Red, Surrounding Skin Color: Normal for skin, Surrounding tissues/wound edges: Normal for skin. Culture sent: No, Progress: New, Treatment: Continue treatment, Comments: Small abrasion at lower end of scar area. Triad q (every) shift." This non-pressure assessment was completed by the wound care nurse. Review of the Weekly CNA Skin Assessment sheet dated 2/2/17, prior to the sacral area found on 2/4/17, documented the resident as having an old skin tear to his left arm. No areas were identified to on the sacrum. A nursing skin assessment from a licensed nurse could not be found prior to the discovery of the sacral area found on 2/4/17. Resident #13's most recent Braden score prior to the 2/4/17 discovery of the sacral areas was documented on 1/20/17. Resident #13 was documented as having a score of 13-14 "Moderate Risk" for skin breakdown. Review of Resident #13's telephone physician	F 314		

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F 314	Continued From page 88 orders dated 2/4/16 documented the following: "2/4/17 Order description: Apply Triad Paste Q (every) SHIFT to inner sacral fold and sacral areas, after cleansing with normal saline. Frequency: Every Shift." This order was created and verified by the wound care nurse. Further review of Resident #13's physician orders dated 2/4/16 documented the following: "2/4/17 Order description: Prostat [3] sugar free 30 ml (milliliters) p.o. (by mouth) BID (twice a day) to promote wound healing." This order was created and verified by the wound care nurse. Review of Resident #13's telephone physician orders dated 11/15/16, revealed that he had an order initiated for an air mattress on 11/15/16. This air mattress continued to be in place during survey 2/21/17 through 2/23/17 and 2/27/17 through 2/28/17. Review of Resident #13's nursing notes dated 2/5/17 at 1:32 p.m., revealed that Resident #13 had been sent out to the hospital. The following was documented: "Remains slow to respond. Is not swallowing or accepting food or fluids. Remained in bed. VSS. (Vital Signs Stable). 114/78 (blood pressure), 89-(pulse), 16-(respirations), 97.9 (temperature), -196% (sic) (oxygen) RA (room air). Spoke with MD (medical doctor) (name of medical doctor) and approved to be sent to eval (evaluate) for AMS (altered mental status). RP (responsible party) (name of rp) aware." Further review of the nursing noted dated 2/5/17 at 2:15 p.m. documented the following: "Resident d/c (discharged) to (Name of Hospital) and was admitted. RP is not holding bed. Will follow up	F 314		

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F 314	Continued From page 89 with hospital regarding return." Review of the emergency department notes dated 2/5/17 at 3:15 p.m. documented in part, the following: "HPI (History of Present Illness) comments: 79 year old with past medical history significant for HTN (high blood pressure), Parkinson's Disease, prostate cancer, hypercholesteremia (high cholesterol) and dementia who presents to the ED (emergency department) via EMS (Emergency Services) with chief complaint of altered mental status. Pt's (patients) daughter reports pt has altered mental status from his baseline with decreased responsiveness, lethargy, and some confusion. Pt's daughter reports pt "not normally very talkative" but says over the last couple of weeks pt has had decreased responsiveness. Pt's daughter states pt has also had difficulty in swallowing and decreased po intake. Pt's daughter states pt is on pureed, thin liquid diet. Pt's temperature was found to be 100.4 F (Fahrenheit) rectally upon arrival to the ED. Pt's daughter stated pt has hx of Parkinson's but recently stopped having tremors. Pt's daughter states staff at pt's nursing home thought pt may have had a seizure about a week ago and was seen at (Name of hospital) and had a negative work up...Physical exam... Stage 3 pressure ulcer to mid sacrum approx (approximately) 1.5 cm (centimeters) in length...Diagnosis management comments: Given febrile (with fever)-check for flu, PNA (pneumonia), uti (urinary tract infection), sx (symptoms) could be from pressure ulcer...will likely need admission due to poor po (by mouth) intake." Review of the hospital history and physical dated 2/5/17 at 5:15 p.m., documented in part, the	F 314		

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following: "(Name of Resident) is a 79 y.o (year old) African American male who is admitted with infected decubitis ulcer...physical exam...skin: unstageable sacral decubitus ulcer, with debris in wound, drainage and odor...Assessment/Plan...Infected decubitis ulcer (2/5/17) -continue with zosyn [4], add vancomycin [5] - Wound Care consult, may need surgical intervention."

Review of the hospital general surgery consult dated 2/6/17 at 6:53 p.m., documents in part, the following: "(Name of Resident #13) is a 79 y.o male who presents with foul smelling sacral ulcer...(Name of Resident #13) is poorly conversant, pleasant 79 M (male) who currently resides in a nursing facility for care of multiple ADL (activities of daily living). Per family history in the electronic record, he has accelerated altered mental status, less interactive from normal baseline over the last month. He has also been admitted to (name of hospital) with recent seizure activity. On a recent examination, he has been found to have a new sacral ulcer. He has been admitted for workup and evaluation. "

Review of the hospital OP (operative) note dated 2/8/17 documents in part, the following: Preoperative diagnoses: 1. Unstageable sacral ulcer. Postoperative diagnoses: 1. Stage IV sacral ulcer, 2. Devitalized skin, subcutaneous tissue and muscle. 3. Gluteal abscess."

Review of the hospital discharge summary dated 2/14/17 at 11:32 a.m., documented in part, the following: "(Name of Resident) is a 79 y.o. admitted to (Name of hospital) and treated for the following: Infected stage 4 sacral ulcer/ Fever POA (present on admission), due to immobility.

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F 314	Continued From page 91 Wound cultures isolated scant E coli [6], Proteus [7] and Strep [8] species, all sensitive to ceftriaxone [9]. Seen by wound and surgery. He is sp (status) post debridement and drainage of abscess on 2/8. He has been on IV (intravenous) ceftriaxone but now going on hospice." Review of Resident #13's nursing notes revealed the following note dated 2/15/17 at 8:36 p.m.: "MDS/Care plan review, (Name of Resident) was readmitted to this facility on 2/14/17 under hospice care; hospital states that (Name of Resident #13) was admitted to them with an infected decub (decubitus) to sacrum; wound care nurse evaluated resident's skin the day before hospitalization and there was only excoriation noted to his sacrum; Received IV ABX at hospital; wound was debrided on 2/8/17...Resident will be done as a significant change with an ARD of 2/20/17 due to hospice care..." Review of Resident #13's care plan dated 11/23/16 and revised 2/4/17, 2/15/17 and 2/16/17 documented the following under category: Pressure: "Needs assist with all ADLS, transfers, and bed mobility; episodes of uncont (incontinence), Receives ASA (aspirin), potential for skin B/D (breakdown), bruising, skin tears, and circulatory skin issues, overlapping toes-receiving protective tx (treatment). Goal: Resident will remain intact. Approach Start Date: 11/23/16: Assess resident for presence of risk factors. Treat, reduce, eliminate risk factors to extent possible. Approach Date: 11/23/16: Conduct a systemic skin inspection (specify weekly, daily, etc. Pay particular attention to the bony prominences. Approach date: 11/23/16: Encourage fluids and nutritional intake. Approach	F 314		

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date 11/23/16: Encourage physical activity, mobility, and range of motion to maximal potential. Approach date 11/23/16: Keep clean and dry as possible. Minimize skin exposure to moisture. Approach date 11/23/16: Report any signs of skin breakdown (sore, tender, red, or broken areas). Approach date 11/23/16: Use INCONT (incontinent) products to maintain personal hygiene and dignity." Resident #13's care plan was updated on 2/4/17 and documented the following: "2/4- open areas noted to sacrum and sacral fold, Triad...Areas in sacrum will heal by 2/14."

Resident #13's care plan was also updated on 2/15/17 and documented the following: "2/15 Resident treated with IV (intravenous) abx (antibiotics) at hospital for wound infection to sacrum-See new treatment orders. Area debrided at the hospital." Resident #13's care plan was updated again on 2/16/17 and documented the following: "Sacral decub (decubitus) ulcer is a stage IV (four). Being followed by wound Dr (doctor)....area on sacrum will heal by 3/12." Further Review of Resident #13's care plan revealed hand written interventions with dated 2/15/16 that documented the following: "Assist in turning and repositioning freq (frequently) when in bed and when (arrow up) in g-chair (geri chair), Tx (treatment per order), refer to wound Dr. as indicated."

Review of Resident #13's February 2017 TARS (Treatment Administration Record) documented that Resident #13 received Triad Paste on 2/4/17 day and evening shift, and 2/5/17 on day shift to his sacral areas.

No documentation such as skin assessments

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regarding Resident #13's sacral area could be found in the clinical record from the time the abrasions were discovered and assessed by the wound care nurse to when the resident was admitted to the emergency department on 2/5/17 at 3:15 p.m. with a stage three sacral pressure ulcer.

Further review of the clinical record revealed that the wound care specialist saw Resident #13 on 2/16/17. The wound care specialist documented the following: "Stage 4 pressure of the sacrum. Wound size 8.2 x 7.8 x 2.0 cm. Exudate: light serous."

On 2/27/17 at 10:19 a.m., an interview was conducted with LPN (licensed practical nurse) #4, a nurse who works regularly with Resident #13. When asked about the process of conducting skin assessments, LPN #4 stated that skin assessments were conducted weekly when the CNA (certified nursing assistant) gives the resident a shower. LPN #4 stated that the CNA will write any new skin areas on a CNA skin assessment sheet, or will document that no new areas were found. LPN #4 stated that she will sign the sheet after the CNA completes the sheet. When asked what her signature signifies, LPN #4 stated that her signature signifies that she has assessed the resident when the CNA alerts her of a new skin area. LPN #4 stated that she will go in and physically look at the new skin area. LPN #4 stated that she will not look at the resident if the CNA documents that no new areas were identified on the sheet. LPN #4 stated that the Unit manager will also sign the skin sheet but will not look at resident unless a new area is identified. When asked if nursing completed a skin assessment separate from the CNA's

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shower assessment, LPN #4 stated that if a new area is found, she will do her own assessment. When asked about the process followed by staff when a new area is identified by the CNA, LPN #4 stated that she would refer the resident to the treatment nurse if she is in the building. LPN #4 stated that if the treatment nurse is not in the building, she herself or the unit manager go in and assess the area and measure. LPN #4 stated that she was off when the sacral areas were identified to Resident #13. LPN #4 stated that when she returned to the facility the following week, Resident #13 was at the hospital. When asked if she was ever made aware or noticed any new skin areas to Resident #13 prior to 2/4/17, LPN #4 stated that she was not aware of any new skin areas or pressure sores and she did not notice any skin areas to Resident #13. LPN #4 stated that the nurse who identified the sacral areas on 2/4/17 no longer worked for the facility. The nurse who found the sacral areas could not be reached for an interview.

On 2/27/17 at 10:32 a.m., an interview was conducted with LPN # 1, the wound care nurse. When asked her role in assessing skin areas, LPN #1 stated that she makes rounds on residents with wounds or assesses new skin areas. LPN #1 stated that nursing will alert her of new skin alterations. LPN #1 stated that the wound MD (medical doctor) also makes rounds every Thursday if a wound needs to be followed by him, such as a wound that looks infected. When asked if she was familiar with Resident #13, LPN #1 stated that she was. When asked if she could described the first time she saw Resident #13's sacral areas, LPN #1 stated that the night shift nurse had alerted her on Saturday morning 2/4/17, that Resident #13 had new

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areas to his sacrum. LPN #1 stated that she evaluated Resident #13 that morning, shortly after she arrived on shift, and agreed with the night shift nurse's treatment plan for Triad paste. When asked what she observed during her assessment, LPN #1 stated that she noticed a small open pin-point area to the top of Resident #13's sacral fold. LPN #1 stated that she also noticed an old scar to the resident's inner sacral fold. LPN #1 stated, "The scar was at the top of the cleft, it was not mushy or anything in the center. I just thought it was the beginning of breakdown." LPN #1 also stated that she noted an abrasion to Resident #13's lower sacrum and also thought it was the beginning of skin breakdown. LPN #1 stated, "I planned for the MD (medical doctor) to see it, but the resident went to the hospital." When asked who conducts weekly skin assessment on residents, LPN #1 stated that usually the CNA do the skin assessments during baths or showers. LPN #1 stated that if there is a change in the resident's skin condition, they will alert the nurse and the nurse will sometimes alert her. LPN #1 stated that she thinks the first time an aide saw a change in Resident #13's skin was on 2/4/17. LPN #1 stated, "I think the CNA on night shift pointed it out to (Name of night shift nurse)." When asked if Resident #13's sacral areas could have been possibly misidentified as abrasions and were pressure ulcers on 2/4/17, LPN #1 stated, "It really didn't look like that. I was shocked when he came back with a stage 4."

On 2/27/17 at 2:12 p.m., an interview was conducted with CNA #23, a CNA who used to regularly work with Resident #13. When asked how often CNAs check the resident's skin, CNA #23 stated, "Everyday when providing care. If there is a new area we will notify the charge

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nurse or treatment nurse if she is on the unit. Nursing would take it from there." CNA #23 stated that she hadn't worked with Resident #13 when his sacral areas were found. She could not recall if Resident #13 had any current sacral areas.

On 2/28/17 at 8:40 a.m., an interview was conducted with CNA (certified nursing assistant) #21, a CNA who had been identified by the DON (director of nursing) to have been the night shift CNA on 2/4/17. CNA #21 stated that she did not find Resident #13's skin area. CNA #21 stated, "He was not my patient that night." CNA #21 stated that she was certain Resident #13's CNA was CNA #42 on 2/4/17, 11-7 shift.

On 2/28/17 at 8:55 a.m., 9:20 a.m., and 10:02 a.m., interviews were attempted with CNA #42. CNA #42 could not be reached for an interview.

On 2/28/17 at 9:55 a.m., observation of Resident #13's wound was conducted with LPN (licensed practical nurse) #1. Resident #13 was observed with a stage 4 pressure ulcer measuring 6.5 x 7 x 2.4 cm (centimeters). Light drainage was noted.

On 2/28/17 at 2:09 p.m., an interview was conducted with CNA (certified nursing assistant) #18, a CNA who works regularly with Resident #13. CNA #18 was asked when CNA's look at the resident's skin. CNA #18 stated, "Basically every day with bed baths and showers. If there are any changes in the skin we report this to the charge nurse or treatment nurse." CNA #18 stated that the nurse would look at the resident's skin after the CNAs alert them of a new condition. When asked if she ever saw Resident #13's skin prior to him going out to the hospital in early

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F 314	Continued From page 97 February, CNA #18 stated that she was not informed the resident had any skin issues until he came back from the hospital. On 2/28/17 at 2:27 p.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing) and ASM #5, the previous DON. When asked if it was possible for a skin area to go from an abrasion to a stage three pressure ulcer in a 24 hour period, ASM #5 stated, "Folks observe wounds in different ways. Maybe it was a DTI (deep tissue injury) and the nurse thought it was an abrasion." ASM#5 stated that the wound care nurse may have misdiagnosed or misstaged Resident #13's sacral area on 2/4/17. When asked if they could find any documentation assessing the sacral areas after the abrasions were found and before the resident went out to the hospital, ASM #2 stated, "I'll see if I can find anything." ASM #5 stated, "I'll help her." On 2/28/17 at 3:01 p.m., an interview was conducted with ASM #4, the wound care physician. When asked if he was familiar with Resident #13, ASM #4 stated that he has saw Resident #13 when he arrived back from the hospital with a stage 4. ASM #4 stated that he did not follow Resident #13 prior to re-admission. When asked if it was possible for an abrasion to the sacral area to turn into a stage three in a 24 hour period, ASM #4 stated that with Resident #13's condition it was very possible for a wound to decondition rapidly. ASM #4 stated, "When I saw him, he was very debilitated." ASM #4 stated, "When the areas were found, they were probably more than just abrasions." On 2/28/17 at 3:38 p.m., ASM #2, the DON and	F 314		

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F 314	Continued From page 98 ASM #5, the previous DON were made aware of the concern for harm. Any documentation to eliminate the concern for harm was requested. When asked the process for conducting skin assessments, ASM #2 stated that CNAs would check the skin during a bath and if a new area is found, the CNAs would alert the nurses. ASM #2 stated that the nurse would come in to evaluate the new area. ASM #2 stated that most of the time, the nurses are dependent on the CNAs to look at the skin. When asked what type of education the CNAs have to assess the residents' skin, ASM #2 stated that the CNAs definitely know if something is different on the resident and to alert the nurse. When asked if a CNA would be able to determine any area of redness, ASM #2 stated they she was confident the CNAs could determine areas of redness. When asked if a CNA was qualified to conduct a skin assessment, ASM #2 stated that the CNAs were not qualified and the nurses should be assessing the skin if a new area is identified and reported. When asked if nursing should be conducting skin assessment in addition to the CNAs doing body checks during showers or care, ASM #2 stated, "Nurses should be checking each resident, every shift." ASM #5 stated that 11-7 nurses used to be assigned residents to do weekly skin assessments. On 2/28/17 at approximately 4:50 p.m., ASM #5 presented a skin integrity policy. When asked when the nurses conduct skin assessments, ASM #5 stated, "Daily. They aren't doing them. That's a problem." No further documentation could be presented regarding Resident #13's sacral wound prior to exit.	F 314		

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F 314	Continued From page 99 Facility policy titled, "Pressure Ulcer Prevention and Care" includes the NPUP [National Pressure Ulcer Advisory Panel] Staging/Coding Guidelines. The following was documented: "Suspected Deep Tissue Injury: Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Further description: Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment. Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. Further description: The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage 1 may be difficult to detect in individuals with dark skin tones. May indicate "at risk" persons. Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ruptured serum filled blister. Further description: Presents as a shiny or dry shallow ulcer without slough or bruising. This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration, or excoriation.	F 314		

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F 314	Continued From page 100 Stage III: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Further description: The depth of a stage III pressure ulcer varies by anatomical location. The bridge of the nose ear, occiput and malleolus do not have subcutaneous tissue and stage III ulcers can be shallow. In contrast, areas of significant adiposty can develop extremely deep stage III pressure ulcers. Bone/tendon is not visible or directly palpable." Stage IV: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. Further description: The depth if a stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput, and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage IV ulcers can extend into the muscle/and or supporting structures mating osteomyelitis possible. Exposed bone/tendon is visible or directly palpable. Unstageable: Full thickness tissue loss in which the base if the ulcer is covered by slough (yellow, tan, gray, green, brown) and/or eschar (tan, brown, black) in the wound bed. Further description: Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed."	F 314		

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F 314	Continued From page 101 The Facility policy titled, "Skin Integrity," documents in part, the following: "Standard: The skin integrity of resident is preserved through adequate nutrition and hydration, daily inspection of the skin, compliance with proper body alignment and positioning and maintenance of maximum mobility. Policy: Residents who have suffered loss of skin integrity receive appropriate treatment. Residents with any broken skin problems are seen by a physician and/or the treatment control nurse. Procedures: 1. Licensed nurse: a. inspects the areas for potential breakdown on a daily basis. b. assess for mobility level, hydration-nutrition status, and presence of irritants, such as tight clothing or topical substances...Follow standards, policies, and procedures for pressure sores..." [1] Metabolic encephalopathy-Encephalopathy is a term for any diffuse disease of the brain that alters brain function or structure. Encephalopathy may be caused by infectious agent (bacteria, virus, or prion), metabolic or mitochondrial dysfunction, brain tumor or increased pressure in the skull, prolonged exposure to toxic elements (including solvents, drugs, radiation, paints, industrial chemicals, and certain metals), chronic progressive trauma, poor nutrition, or lack of oxygen or blood flow to the brain. The hallmark of encephalopathy is an altered mental state. This information was obtained from The National Institutes of Health. https://www.ninds.nih.gov/Disorders/All-Disorders/Encephalopathy-Information-Page.. [2] Stage IV Pressure Ulcer- Full thickness tissue loss with exposed bone, tendon, or muscle.	F 314		

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Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. This information was obtained from the National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm.

[3] Prostat- Liquid based nutritional supplement that contains protein that may prevent malnutrition and weight loss. This information was obtained from The National Institutes of Health. https://www.cancer.gov/publications/dictionaries/cancer-drug?cdrid=776922.

[4] Zosyn- Used to treat bacterial infections in many parts of the body. This information was obtained from the National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011750/?report=details.

[5] Vancomycin- Used to reduce the development of drug-resistant bacteria. Vancomycin should be used only to treat or prevent infections that are proven or strongly suspected to be caused by bacteria. This information is obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=e78bfa6d-d257-46a0-84a7-8d722c58830d.

[6] E.Coli-Escherichia coli (E. coli) bacteria live in the intestines of people and animals, and are key to a healthy intestinal tract. Most E. coli strains are harmless, but some can cause diarrhea through contact with contaminated food or water while other strains can cause urinary tract infections, respiratory illness and pneumonia. This information was obtained from The National Institutes of Health. https://www.niaid.nih.gov/diseases-conditions/e-c

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F 314	Continued From page 103 oli. [7] Proteus- Bacteria that is normally associated with UTIs (Urinary tract infections). [8] Streptococcus- There are many types of Streptococcus bacteria. Some can cause disease such as strep throat, meningitis and pneumonia. Others keep us healthy and are found in areas of the human body such as intestines, skin, mouth and nose. This information was obtained from the National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0024688/. [9] Ceftriaxone- Used to treat bacterial infections in many different parts of the body. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009521/. 2. Resident #4 was documented as having a stage II pressure sore on the sacrum and as receiving treatments without any initial or ongoing wound measurements/assessments and on 1/5/17 the wound care physician identified a deterioration of the pressure sore status to a stage 3 (2) with yellow necrotic wound tissue. Resident #4 was admitted to the facility on 6/13/13 and most recently readmitted on 5/2/16 with diagnoses including, but not limited to: heart disease, breast cancer, diabetes, and high blood pressure. On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 1/22/17, Resident #4 was coded as being severely cognitively	F 314		

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impaired for making daily decisions. She was coded as being completely dependent on two staff members for bed mobility and transfers. She was coded as always being incontinent of both bowel and bladder. She was coded as having one stage 3 pressure ulcer that was not present at the time of her most recent admission.

On the quarterly MDS with an assessment reference date of 10/22/16, Resident #4 was coded as being moderately cognitively impaired for making daily decisions. She was coded as being completely dependent on two staff members for bed mobility, and as requiring the extensive assistance of two staff members for transfers. She was coded as being frequently incontinent of both bowel and bladder. She was coded as having one stage 2 pressure ulcer (9), with an origin date of 10/17/16.

On 2/22/17 at 10:05 a.m., observation was made of Resident #4 as she received a dressing change on her sacral pressure ulcer by LPN (license practical nurse) #1, the wound nurse. At the time of the observation, the wound measured approximately 8 X 9 X 1 cm (centimeters), and was described by LPN #1 as "a stage 4 (3)." The wound bed contained approximately 20% pink granulation tissue (4) and approximately 80% dead tissue. LPN #1 stated that she is the wound nurse for all the residents in the facility.

A review of the physician's orders revealed the following order, dated and electronically signed by the physician on 10/17/16: "Cleanse open area to left buttock with DWC (dermal wound cleanser). Apply Santyl and dry dressing QD (every day) and prn (as needed)." This order was discontinued 11/16/16. A review of the TAR (treatment

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administration record) for October 2016 revealed this treatment was applied as ordered.

A review of the clinical record revealed a quarterly nursing assessment completed by LPN #1 on 10/19/16. On this assessment, the resident was documented, by way of a check-off item on the assessment, to have a Stage 2 pressure ulcer. This assessment contained no description, size or further narrative information for this wound.

A review of nursing shift reports dated 11/1/16, 11/2/16, and 11/3/16 and signed by LPN #4 revealed, by way of check-off items on the assessments, that Resident #4 had a Stage 2 pressure ulcer. Theses assessments contained no description, size or further narrative information for this wound.

A review of the weekly CNA (certified nursing assistant) skin assessment dated 11/17/16 for Resident #4 revealed three initials in a box beside the instructions: "Initial here if no abnormalities seen." The CNA whose initials were in the box was not available for interview.

A review of the physician's orders for Resident #4 revealed the following order, dated and signed on 11/16/16: "Cleanse open area to left buttock with Normal Saline (5). Apply Santyl (6) and dry dressing QD (every day) and prn (as needed) until healed." This order was documented as discontinued on 12/16/16.

A review of the TARs (treatment administration records) for November and December 2016 revealed this treatment was completed as

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F 314	Continued From page 106 ordered. Further review of the clinical record revealed no evidence of nurses' notes or wound assessments of Resident #4's buttocks area for 11/16/16. A review of the weekly CNA (certified nursing assistant) skin assessment dated 12/13/16 for Resident #4 revealed three initials in a box beside the instructions: "Initial here if no abnormalities seen." A review of the physician's orders for Resident #4 revealed the following order, dated and signed on 12/16/16: Cleanse open area to sacral fold with 1/4 str. (one-quarter strength) Dakins solution (7). Skin prep (8) peri wound (skin around the wound). Apply Santyl and dry dressing QD and prn until healed." This order was documented discontinued on 1/19/17. A review of the TARs for December 2016 and January 2017 revealed this treatment was completed as ordered. Further review of the clinical record revealed no evidence of nurses' notes or wound assessments to include meaurements and staging of Resident #4's buttocks area for 12/16/16. Further review of the clinical record revealed a document titled "Non-Pressure Skin Condition Report" dated 12/21/16, completed by LPN # 1. The document contained the following entries: - "Site/Location (Indicate on body form): sacrum - Condition is: Other - shear - Size in cm (centimeters): 1.8 X 5 X .01 - Exudate (drainage) type: Serous (clear) - Exudate amount: scant	F 314		

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F 314	Continued From page 107 - Wound bed: Pink/Beefy red - Progress: Not changed - Treatment: Continue - Comments: Two separate areas, grouped together in measurement." Further review of the clinical record revealed a document titled "Non-Pressure Skin Condition Report" dated 12/28/16, completed by LPN # 1. The document contained the following entries: - "Site/Location (Indicate on body form): sacrum - Condition is: Other - shear - Size in cm (centimeters): 2.4 X 5 X .01 - Exudate (drainage) type: Serous (clear) - Exudate amount: scant - Wound bed: Pink/Beefy red - Progress: Deteriorated - Treatment: Continue - Comments: Two separate areas, grouped together in measurement." Further review of the clinical record revealed no further documentation regarding the open area on Resident #4's sacrum between 12/28/16 and 1/5/17. A review of the weekly CNA (certified nursing assistant) skin assessment dated 1/4/17 for Resident #4 revealed three initials in a box beside the instructions: "Initial here if no abnormalities seen." Further review of the clinical record revealed a document titled "Wound Care Specialist Evaluation" dated 1/5/17 and signed by ASM (administrative staff member) #4 on 1/5/17, the wound doctor. The document contained the following: "Chief Complaint: Patient has a wound on their sacrum...At the request of [name of	F 314		

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F 314	Continued From page 108 primary care physician], this 101 year old female was seen and evaluated today. She presents with a stage 3 pressure wound of the medial sacrum of at least 1 day(s) in duration. There is light serous exudate. There is no indication of pain associated with this condition...Stage 3 Pressure Wound of the Medial Sacrum Focused Wound Exam...Etiology (Quality): Pressure, MDS 3.0 Stage 3, Duration > 1 (greater than one) days, Objective: Healing, Manage Pain, Wound Size (LXWXD): 4.2 X 4.9 X 0.1 cm, Surface Area 20.58 cm [squared], Cluster Wound, Exudate: Light Serous, Yellow Necrotic: 55%, Granulation Tissue: 10%, Skin: 35%, 1/5 (1/5/17) wound over old scar tissue, Dressing: Santyl - once daily, dry protective dressing - once daily." A review of Resident #4's comprehensive care plan dated 11/3/16 and most recently updated on 1/19/17 revealed, in part, the following: "Category: ADL (activities of daily living) Functional/Rehabilitation Potential: Continues to decline overall; extensive to total assist of one or two with ADLS, transfers and bed mobility; provide comfort care measures. Category: Pressure Ulcer. Overall decline; Potential for pressure ulcers, bruising, skin tears, diabetic and circulatory skin issues as well; preventive tx (treatment) to sacrum and btw (between) toes. 12/16 - see Tx order [change]; open areas to sacral fold. See tx order. 1/18 area to sacrum stage III; 1/19 cont. to have area to sacrum - cont (continue) to decline...Approach (all approaches dated 11/3/16): Assess resident for presence of risk factors. Treat, reduce, eliminate risk factors to extent possible. Assist in turning and repositioning routinely. Conduct a systematic skin inspection routinely. Pay particular attention to the bony prominences. Diet as ordered.	F 314		

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Encourage fluids. Encourage physical activity, mobility, and range of motion to maximal potential. Minimize skin exposure to moisture. Monitor and report labs (laboratory tests) as ordered. Provide incontinence care after each incontinent episode. Report any signs of skin breakdown (sore, tender, red, or broken areas). Supplements/vitamins as ordered. Take special care when assisting in care in attempts to reduce skin tears and bruising. Treatments per order; refer to wound md (doctor) as indicated. Use incontinent products to maintain personal hygiene and dignity. Use moisture barrier product to perineal area. 1/18 - See new tx order. 1/20 - air mattress per order."

On 2/23/17 at 12:45 p.m., LPN #1, the wound nurse was interviewed regarding Resident #4's sacral wounds. She reviewed the 12/21/16 and 12/28/16 Non Pressure Skin Condition Reports and stated: "There were two separate places. Then one healed up. And the other one opened up." When asked to provide the surveyor with documentation regarding the size, stage and condition of these wounds which precipitated the 11/16/16 and 12/16/16 orders, she stated she was not sure if any documentation existed, and that she would search for it.

On 2/23/17 at 3:05 p.m., LPN #1 was interviewed again regarding Resident #4's sacral wounds. LPN #1stated: "The wound doctor saw her back in late summer (2016) for open areas on her sacrum and buttocks. But he stopped seeing her in early September. I think that area had healed. On 11/16/16, we started cleaning an open area with normal saline and applying Santyl." She stated that as best she remembered, there was only one open area being treated at that time.

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F 314	Continued From page 110 When asked to provide the documentation regarding the size, stage and condition of this area to which she was applying a debridement agent, LPN #1 stated: "There is no documentation as to why." When asked what the wound looked like, she stated she could not recall. When asked to provide skin assessments between 11/16/16 and 12/16/16 (when the treatment was changed), LPN #1 stated: "There is no documentation." LPN #1 stated: "On 12/16/16, the order was changed to use the Dakins solution for cleansing the wound." When asked to provide documentation as to why the treatment needed to be changed, LPN #1 stated: "There is no documentation as to why." When asked why Dakins would be used instead of normal saline, LPN #1 stated: "You would use Dakins if you needed a cleanser that would fight against bacteria because Dakins kills bacteria." She stated she thought that by 12/16/16, Resident #4 had two open areas on her sacrum. She stated she could not locate any documentation to verify what she remembered. When asked if she remembered anything about the open areas from doing the daily treatments, LPN #1 stated: "I did not think they were pressure. Not at that time, but [ASM #4] told me it was pressure. He said it wasn't shearing, like I had in my notes. I was wrong about that." When asked the process for identifying, staging, assessing and monitoring a pressure area, she stated there should be weekly skin assessments, with measurements and staging. She stated she would ordinarily write a progress note to accompany the weekly assessments. When asked about the process for referring a resident to the wound specialist, LPN #1stated: "If the wound is clean and is a stage 2 or less, we will do a standard treatment. But if the wound starts with	F 314		

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necrosis or getting any kind of overlay, we will start using the Santyl. [ASM #4] gets called in if I'm using Santyl." When asked why ASM #4 was not called until 1/5/17 when the Santyl treatment began on 11/16/16, LPN #1 stated: "I'm not sure. [ASM #4] may have been on vacation then." LPN #1 stated: "This was my fault. I should have been measuring it and documenting assessments all along. I should have had weekly measurements, and I should have notified the PCP (primary care physician) about what was going on. I know I should have been doing more."

On 2/23/17 at 4:10 p.m., ASM #4 was interviewed. When asked if he remembered seeing Resident #4 in August or September of 2016, he stated he did not remember seeing her at that time. When asked if he remembered seeing the wound on 1/5/17, ASM #4 stated: "No, I don't have a memory of seeing it." He stated his note indicates the scar tissue Resident #4 had from a previous wound broke down and reopened to create the wound he staged at Stage 3 on 1/5/17. When asked if he had been aware that Resident #4 had been treated with Santyl prior to his seeing the wound on 1/5/17, he stated he was not aware. When asked to speak to the avoidability of Resident #4's pressure ulcer, ASM #4 stated: "I guess you could make a case that nothing is truly, purely unavoidable. However, this lady is old. It is not an excuse. But she is old and debilitated. Even at six months out from a wound, scar tissue is only 60% strength of regular skin. She was more likely than not going to have skin failure."

On 2/23/17 at 4:25 p.m., ASM #2, the director of nursing was interviewed regarding the skin

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assessment process at the facility. She stated the CNAs are supposed to do weekly skin assessments, usually coinciding with a resident's shower. She stated if a resident has a pressure area or other type of wound, a staff member, usually the wound nurse, should be assessing and documenting on the wound weekly.

On 2/23/17 at 4:40 p.m., ASM #1, the administrator, and ASM #2 were informed of these concerns.

On 2/27/17 at 10:00 a.m., RN (registered nurse) #5, a unit manager, was interviewed. When asked about her signatures on the above-referenced CNA skin assessment sheets (11/17/16 and 12/13/16), RN #5stated: "To my knowledge, I didn't document anything myself. I didn't directly chart. I may have seen [Resident #4] once with [ASM #4]." She stated that the floor nurses and wound nurse were responsible for reporting the skin issues. She stated Resident #4 was declining medically. When asked about her role with skin assessments and wounds, she stated she intervenes if there is a need to facilitate action from the wound nurse and/or the floor nurse. She stated she thought that the wound nurse was aware of and "handling" Resident #4's skin issues. She stated unit managers may perform wound care if it is not done by either the wound nurse or the floor nurse. She stated she would not necessarily document on the wound unless she performed the wound care herself. She stated wound care documentation should include appearance, measurements, and a description of drainage.

On 2/27/17 at 10:10 a.m., LPN #4, a floor nurse who signed the 11/17/16 CNA skin assessment

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sheet, was interviewed. She stated the CNA completes the skin assessment when the resident receives a shower. The CNA documents the findings on a skin a sheet of paper with the outline of a body on it. She stated the floor nurse and unit manager sign off on the sheet. When asked what her signature on the 11/17/16 means, she stated her signature signifies that she has assessed the resident; if there is a problem area, that she has looked at the area and initiated a treatment. She stated Resident #4 had a pressure ulcer on her sacrum, and that she had indicated this on the 11/3/16 CNA weekly skin assessment sheet. She stated she thought Resident #4 was receiving treatments for the pressure ulcer, but that she did not remember the stage. She stated that there is a place on the weekly assessment sheets for the CNA to state that there are no new areas noted. This is the box where the CNA puts her/his initials. She stated the floor nurse and unit manager also sign off on this. She stated if there was no indication of new areas, she would not go and look at the resident.

On 2/27/17 at 3:25 p.m., CNA #8 was interviewed regarding skin assessments. CNA #8 stated: "When we give the showers we make sure there is nothing new and that old areas are healing. We look at the skin." CNA #8 was asked if anyone else was doing assessments of residents' skin. CNA #8 stated: "The aides are primarily doing the skin assessments, documenting on the skin assessment sheets. The nurses do a skin assessment on admission. If I haven't seen someone (a resident) for a couple of days and see something, I'll ask the nurse if it's something new." When asked about the education she had received in regards to performing and

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F 314	Continued From page 114 documenting skin assessments, CNA #8 she stated: "We have had in-services for skin assessments and wound care. We haven't had any specific education about the skin assessments, just documenting on the skin assessment sheet." On 2/28/17 at 9:20 a.m., LPN #16 was interviewed. She stated her signature on the CNA weekly skin assessment means that the CNA has looked at the skin head to toe and has found no skin issues. She stated that she looks at the resident's skin no matter what the CNA states. She stated her signature also indicates that she concurs with what the CNA states. When asked about her signature on the 12/13/16 CNA weekly skin assessment sheet meant, LPN #16 stated: "That is too far back for me to remember." On 2/28/17 at 4:00 p.m., ASM #2 was interviewed. When asked who is responsible for skin assessments and wound care, she stated the wound care nurse is responsible for any wounds. When asked who is responsible for the routine skin assessments, ASM #2 stated: "They are performed by the nurse on admission and then prn (as needed). The CNAs do the weekly skin assessments." When asked to clarify who is responsible for the weekly skin assessments, she stated the CNAs perform the skin assessments at the time of the weekly shower, document any abnormalities, and notify the nurses. When asked the process for the nurse to perform a skin assessment, she stated: "On admission, quarterly, and if the CNA states there is a problem." When asked which staff members are qualified to perform skin assessments, she responded: "The nurse." When asked if a CNA	F 314		

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F 314	Continued From page 115 is qualified under training and scope of practice to perform skin assessments, ASM #2 stated: "No." When asked about training provided to CNAs regarding routine skin assessments, ASM #2 stated: "CNAs know the residents, and usually the same CNA does [the residents"] showers each week. The CNAs are not trained to do skin assessments." During the survey Resident #4's Braden Scale assessments were requested and not provided. A review of the facility policy entitled "Skin Integrity" revealed, in part, the following: "Policy: To promote a systematic approach and monitoring process for residents with pressure ulcers and devise an appropriate plan of care to meet the resident's needs in regards to wound management...Residents who are unable to reposition independently will be turned and repositioned every 2 hours according to the established facility turn schedule...The wound nurse will monitor the skin assessments weekly to ensure treatments and interventions are initiated as needed to promote skin integrity and minimize the risk of pressure ulcer formation...Certified Nursing Assistants will be instructed to inspect the skin weekly, document on CNA skin sheet and report any concerns regarding the resident's skin integrity to the Charge Nurse and wound nurse...Pressure ulcers that are currently being treated will be described in the weekly wound documentation...Documentation regarding pressure ulcers and/or wounds will be made in the clinical record at least weekly. Documentation will include but is not limited to the following: 1. Location of the wound. 2. Stage of the wound. 3. Measurement of the wound or	F 314		

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ulcer including width, length and depth. 4. Presence, location and extent of any undermining or tunneling. 5. Description of any wound drainage. 6. Description of the wound bed. 7. Description of wound edges and surrounding tissue. 8. Current treatment order and response to current treatment. 9. Compliance or noncompliance with the plan of care. 10. Pressure Reduction Devices. 11. intervention to promote healing. 12. Physician notification. 13. Responsible party notification. 14. Negative factors affecting wound healing...If a pressure ulcer fails to show some evidence of progress toward healing within 2 - 4 weeks, the pressure ulcer (including potential complications) and the resident's overall clinical condition will be reassessed. Re-evaluation of the treatment plan including determining whether to continue or modify current interventions is also indicated...The Unit Manager, along with the Multidisciplinary Care Plan Team, if deciding to retain the current regimen will document the rational (sic) for continuing the present treatment."

A review of a separate policy entitled "Skin Integrity" revealed, in part, the following: "STANDARD: The skin integrity of resident is preserved through adequate nutrition and hydration, daily inspection of the skin, compliance with proper body alignment and positioning, and maintenance of maximum mobility. POLICY: Residents who have suffered loss of skin integrity receive appropriate treatment. Residents with any broken skin problems are seen by a physician and/or the treatment nurse. PROCEDURES: Licensed nurse: inspects areas for potential breakdown on a daily basis...The licensed nurse implements a program

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F 314	Continued From page 117 of...documentation (sic) the condition of areas being treated once a week that includes size, depth, drainage, healing, medication, and devices used to reduce pressure...Follow standards, policies, and procedures for pressure sores." Treatment of Pressure Ulcers, U.S. Department of Health and Human Services, Publication Number 15, documents, in part: "The assessment of an individual with a pressure ulcer is the basis for planning treatment, evaluating treatment effects, and communicating with other caregivers. Initially, the clinician should determine the location, stage, and size of the pressure ulcer. Accurate staging and description of pressure sores is a perquisite to the development and implementation of appropriate, effective treatment protocols and to effective, ongoing monitoring of tissue healing." The Pressure Ulcer Treatment Quick Reference Guide by NPUAP states on page 8 concerning pressure ulcer assessment, "Asses the pressure ulcer initially and re-assess it at least weekly, documenting findings...A 2-week period is recommended for evaluating progress toward healing. However, weekly assessments provide an opportunity for the health care professional to detect early complications and the need for changes in the treatment plan." Page 9 of this reference states, "With each dressing change, observe the pressure ulcer for developments that may indicate the need for a change in treatment (e.g., wound improvement, wound deterioration, more or less exudate, signs of infection, or other complications)...Assess and accurately document physical characteristics such as location, Category/Stage, size, tissue type (s), wound bed and periwound condition, wound edges, sinus	F 314		

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tracts, undermining, tunneling, exudate, necrotic tissue, odor, presence/absence of granulation tissue, and epithelialization." Page 10 of this reference states, "Re-evaluate the pressure ulcer, the plan of care, and the individual if the pressure ulcer does not show progress toward healing within 2 weeks (or as expected given the individual's overall condition and ability to heal)...Signs of deterioration should be addressed immediately."

(1) The NPUAP (National Pressure Ulcer Advisory Panel) defines a pressure ulcer as a "...localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction." This information is taken from Pressure Ulcer Staging Revised by NPUAP. Copyright 2007. National Pressure Ulcer Advisory Panel. 8/3/2009 http://www.npuap.org.pr2.htm.

(2) Stage 3 - Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. This information was obtained from the website http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagescategories/.

(3) Stage 4 - Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling

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F 314	Continued From page 119 often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. This information was obtained from the website https://www.npuap.org/national-pressure-ulcer-advisory-panel-npuap-announces-a-change-in-terminology-from-pressure-ulcer-to-pressure-injury-and-updates-the-stages-of-pressure-injury/. (4) Granulation - "Red, moist tissue is indicative of granulation tissue, which is progressing toward healing." Potter and Perry, Fundamentals of Nursing, Sixth edition, page 1487. (5) Normal saline is "A sterile, nonpyrogenic solution of electrolytes in water for injection intended only for sterile irrigation, rinsing, dilution and cell washing purposes." This information is taken from the website https://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archiveid=2363. (6) Santyl - "Collagenase Santyl® Ointment is a sterile enzymatic debriding ointment which contains 250 collagenase units per gram of white petrolatum USP. The enzyme collagenase is derived from the fermentation by Clostridium histolyticum. It possesses the unique ability to digest collagen in necrotic tissue." This information is taken from the website https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=a7bf0341-49ff-4338-a339-679a3f3f953d. (7) Dakins - Used to "prevent and treat infections of the skin and tissue. Pre and post surgery. Cuts, abrasions and skin ulcers." This information is taken from the website https://dailymed.nlm.nih.gov/dailymed/drugInfo.cf	F 314		

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F 314	Continued From page 120 m?setid=a0ee103e-1f9c-4ffb-aafe-bb49d30f7816 . (8) "Sureprep® is a fast drying skin protectant. Vapor permeable and delivers protection from friction and incontinence. The transparent barrier may be used on periwound, peristomal or areas that come in contact with bodily fluids." This information is taken from the manufacturer's website https://www.medline.com/product/Sureprep-Skin-Protectant-Wipe/Liquid-Bandages/Z05-PF00058. (9) Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions). This information is taken from the website <http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ >	F 314		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is	F 315	1. Nursing staff has been made aware of the observations made by the surveyors with regards to resident #12's foley catheter tubing Resident #12's foley tubing will be in the privacy bag with foley catheter bag, off of the floor and above the level of the bag to ensure	03/01/17

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F 315	Continued From page 121 continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide appropriate treatment and services for	F 315	cont... drainage and prevent contamination. 2. All residents with foley catheters will have the tubing off the floor and above the foley bag level. 3. The nursing staff has been educated on foley catheters and infection control by the DON or designee. All are awareof the importance of preventing the tubing frombeing lower than the foley bag and off of the floor. 4. Residents who have foley catheters will be monitored dally by the unit manager and charge nurse. **UTI**'s will be monitored by the risk management committee weekly and QA committee quarterly.	03/01/17 03/29/17 03/22/17

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F 315	Continued From page 122 the care of a Foley catheter (1) to prevent urinary tract infections for one of 26 residents in the survey sample, Resident #12. The facility staff failed to keep Foley catheter tubing off the floor on 2/21/17 and 2/22/17 for Resident #12. The findings include: Resident #12 was admitted to the facility on 4/2/12 with diagnoses including, but not limited to: dementia with behaviors, high blood pressure, anxiety, and urinary retention. On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 11/25/16, Resident #12 was coded as being moderately impaired for making daily decisions. She was coded as having a catheter in place. On the following dates and times, Resident #12 was observed sitting in her wheelchair in the day room, with approximately four inches of the tubing from the Foley catheter in contact with the floor: 2/21/17 at 4:55 p.m.; 2/22/17 at 1:30 p.m.; 1/22/17 at 2:25 p.m.; and 1/23/17 at 10:55 a.m. A review of the physician's orders for Resident #12 revealed the following order, written 8/6/14 and signed electronically by the physician: "Foley cath (catheter) to straight drainage q shift (every shift)." A review of the comprehensive care plan dated 11/30/16 and dated 12/15/16 revealed, in part, the following: "Foley cath to straight drainage per order; Irrigate Foley per order; Change Foley and Foley bag as ordered and prn (as needed); Foley care per order."	F 315		

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F 315	Continued From page 123 On 2/23/17 at 11:05 a.m., CNA (certified nursing assistant) #32 accompanied the surveyor to the day room to observe Resident #12. When asked what she noticed about Resident #12's Foley equipment, she stated: "It should have been stuck down more. The tubing should not be on the floor." When asked why this was important, she stated that the tubing should not be located in a place where it could become contaminated. On 2/23/17 at 11:15 a.m., LPN (licensed practical nurse) #13 accompanied the surveyor to the day room to observe Resident #12. When asked about the resident's catheter tubing, LPN #13 stated: "I would try to reposition it to get it off the floor. It's standard cleanliness. The Foley is an opening into the body. We should try to keep the resident from getting a UTI (urinary tract infection) or infection." On 2/23/17 at 4:40 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. A review of the facility policy entitled "Urinary Catheter Care" revealed no information related to the contamination of the catheter tubing. No further information was provided prior to exit. (1) "A Foley catheter is a soft, plastic or rubber tube that is inserted into the bladder to drain the urine." This information is taken from the website http://www.nlm.nih.gov/medlineplus/ency/article/003981.htm. According to Fundamentals of Nursing Lippincott	F 315		

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F 315	Continued From page 124 Williams and Wilkins Eighth Edition 2006, Lippincott Company, page 757, titled Renal and Urinary Disorders, under the heading "Management of a Patient with an Indwelling Catheter and Closed Drainage System" the subheading: "Maintaining a closed drainage system: 2. Maintain an unobstructed urine flow. b. Urine should not be allowed to collect in tubing because free flow of urine must be maintained to prevent urinary tract infection. Improper drainage occurs when the tubing is kinked or twisted, allowing pools of urine to collect in the tubing. c. Keep the bag off the floor to prevent bacterial contamination." According to Mosby's Textbook for Long-Term Care Assistants, Fourth Edition, 2003. Page 363, "Do not let the drainage bag rest on the floor. This can contaminate the system....Coil the drainage tubing on the bed....Tubing must not loop below the drainage bag..." And on page 366, "A closed drainage system is used for indwelling catheters. Nothing can enter the system from the catheter to the drainage bag....Infection can occur if microbes enter the drainage system. The microbes can travel up the tubing or catheter into the bladder and kidneys. A urinary tract infection can threaten health and life."	F 315		
F 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and	F 323	1a. Upon assessment of Resident #7,#14,#3, the use of the bolsters were discontiuned. Resident #7 fall mats and bed pad alaram are in place and checked every 2 hours while in bed. Sitters in place for #7 and #3 from 2/22/17 to 3/9/17. 1B. Resident #7, #14, #3 have not had a fall from bed for past 2 weeks and upon assessment it was determined that a trial without sitters and 30 min checks by nurses would	02/23/17

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F 323	Continued From page 125 (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure a safe environment free of accidents and hazards for three of 26 residents in the survey sample, Residents #7, #14, and #3. 1.a. On 5/17/16 Resident #3 sustained a fall from the bed and the facility staff failed implemented bed bolsters (wedge shaped foam devices 34 inches long by 7 inches height by 8 inches depth placed on the edge and located mid mattress on both sides of the mattress and secured to the bedframe with straps that buckle with a plastic fastener) to prevent falls. On 1/25/17 the resident sustained another fall by crawling over the bolsters. The facility staff failed to reassess the safe use of the bed bolsters for Resident #7	F 323	cont 1B... be instituted for #7 and #3 while in bed 2. 100% Assessment of all residents on Bolsters was completed and it was decided all bolsters were removed from facility. 100% assessments of those on fall mats and bed pad alarms for proper use. 3. Inserviced nursing staff regarding use and safety concerns, staff educated that bolsters are no longer used in our facility. Also when in bed, bed should be in lowest position, mats in place , bed pad alarm turned on. 4. Risk Managment will monitor weekly, all those with fall mats and bed pad alarms to ensure proper use and effectiveness. QA committee will monitor quarterly.	02/23/17 02/23/17 03/22/17

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following the fall. During the survey Resident #7 was observed with bed bolsters in place lying in bed without a fall mat and bed alarm in place as ordered by the physician. Bolster use continued for a total of 16 residents in the facility even though the facility did not have a process or policy for the assessment to determine appropriateness and safe use of the bolsters for residents or for the operationalization of the bolsters. In addition observation of Resident #7's bed bolster in during the survey revealed a space between the mattress and the bolster through which this surveyors arm was easily inserted creating an additional hazard for residents to become entrapped.

b. The facility staff failed to implement Resident #7's bed alarm and fall mats per physician's orders.

2. Resident #14 fell on 10/7/16 and the facility placed bed bolsters on the resident's bed without any assessment for the appropriateness and safe use of the bed bolsters as an intervention for Resident #14. On 12/1/16 Resident #14 was observed sitting on the fall mat beside the bed (the bed bolsters had been moved). On 12/27/16, Resident #14 was observed on the fall mat beside the bed. On 2/14/17 Resident #14 attempted to crawl over the bed bolster while attempting to get out of bed and slid to the floor mat. The facility staff failed to reassess the safe use of bed bolsters after each fall.

3. The facility staff failed to evaluate and assess the appropriate use of bolsters [1] (wedge shaped foam devices 34 inches long by 7 inches height by 8 inches depth placed on the edge and located mid mattress on both sides of the mattress and

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F 323	Continued From page 127 secured to the bedframe with straps that buckle) for the prevention of falls out of the bed after placing them on Resident #3's bed for safety on 1/5/17. Resident #3 subsequently fell out of his bed on 2/11/17, while the bolsters were in place and the facility staff failed to reassess the safe use of the bed bolsters for Resident #3 following the fall. The findings include: 1.a. On 2/21/17 at 1:25 p.m., upon entering the facility and during the initial tour, a concern regarding elevated parameters on the sides of some residents' mattresses was identified. This concern was highlighted as an area of concern and investigated during the survey. Resident #7 was admitted to the facility on 6/23/14 and readmitted to the facility on 6/18/15. Resident #7's diagnoses included but were not limited to: dementia with lewy bodies (1), Parkinson's disease (2), generalized anxiety disorder and history of falling. Resident #7's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/24/16, coded the resident as being severely cognitively impaired, scoring a three out of a possible 15 on the brief interview for mental status. Section G coded Resident #7 as requiring extensive assistance of two or more staff with bed mobility, transfers and walking in the corridor. Review of Resident #7's clinical record revealed a quarterly fall risk assessment dated 3/29/16 that documented Resident #7 was disoriented times three with diminished safety awareness, presented with adequate vision, decreased	F 323		

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muscular coordination, impaired mobility, continent, received antidepressants (3), antipsychotics (4)/neuroleptics (4) and laxatives (5), presented with a history of one or two falls in the last three months, and presented with perceptual, neuromuscular/functional and psychiatric or cognitive conditions. The total score was 16, indicating Resident #7 presented with a high risk for falls.

A nurse's note dated 5/17/16 documented, "AT 0845 (8:45 a.m.) RESIDENT'S BED PAD ALARM NOTED TO BE GOING OFF AND RESIDENT YELLING OUT IN ROOM. UPON ENTERING ROOM RESIDENT NOTED ON BILATERAL KNEES ON FAR SIDE OF THE BED. ASSESSMENT PERFORMED WITH NO INJURIES OR BRUISING NOTED. VSS (vital signs stable). WHEN QUESTIONED RESIDENT STATED HE DIDN'T HAVE ANY PAIN. MD (medical doctor) AND RP (responsible party) AWARE OF FALL AND NEW ORDER WRITTEN AND NOTED FOR BOLSTERS TO BILATERAL BEDSIDE WHILE IN BED."

A fall investigation dated 5/17/16 documented, "Resident's bed pad alarm noted going off & resident noted yelling out in room; upon entering room resident noted on knees on far side of bed. No bruising or injuries noted...Action taken: (a check mark beside) Other- Bolsters to bilateral bedside..." A unit manager's investigation report with an incident date of 5/17/16 documented, "Resident's bed pad alarm noted going off & resident noted yelling out in room; upon entering room resident noted on knees on far side of bed. No bruising or injuries noted..."

Resident #7's comprehensive care plan with a

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problem start date of 3/29/16 documented, "Category: Falls- HIGH FALL RISK R/T (related to) CONFUSION, COMBATIVE BEHAVIOR; INCREASED ANXIETY; PSYCHOTROPIC MEDS (medications); VISION LOSS; SEVERAL FALLS SINCES (sic) ADMIT (admission)...5/17- Resident fell OOB (out of bed) 0 injury...5/17 -Bolsters to Bil (bilateral) bed @ all x's (times) in bed..." The care plan and the clinical record failed to document an assessment for the safe use of the bolsters implemented for Resident #7.

A physician's order dated 5/17/16 documented, "bolsters to bilateral bedside at all times while in bed." Resident #7's May 2016 through February 2017 TARs (treatment administration records) documented, "bolsters to bilateral bedside at all times while in bed..."

A post fall observation form completed on 5/19/16 by the RN (registered nurse) #1 (the quality assurance nurse/ assistant director of nursing) documented Resident #7 fell in his room on 5/17/16. A description of the fall documented, "Resident's bed pad alarm noted going off and resident noted yelling out in room, upon entering room resident noted on knees on far side of bed." The form documented Resident #7 was in bed prior to the fall, the resident was alert with confusion, the resident's usual ambulatory status was assistance of one with/without a device and a bed pad alarm, fall alarm and fall mats were in use at the time of the fall. The form further documented, "Describe measures to be taken to prevent further falls- bolsters to b/l (bilateral) bedside..."

Review of Resident #7's clinical record failed to reveal occupational therapy notes.

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F 323	Continued From page 130 A rehabilitation screening form signed by the speech therapist on 5/25/16 documented, "Screen completed and patient not picked up in therapy. No change in function per interview (with) Resident & nursing staff. Tx (Treatment) not indicated at this time." The form failed to document any information regarding bed bolsters. Review of physical therapy notes from 8/30/16 through 10/7/16 failed to document information regarding bed bolsters. A rehabilitation screening form signed by the speech therapist on 9/8/16 documented, "Screen completed and patient not picked up in therapy. Pt (Patient) functioning at baseline levels within areas of swallowing & cognitive-communication function." The form failed to document any information regarding bed bolsters. A quarterly fall risk assessment dated 9/29/16 documented Resident #7 presented with intermittent confusion, poor recall, judgement and safety awareness; presented with adequate vision, required the use of assistive devices (cane, walker or wheelchair), was ambulatory and incontinent, received anticoagulants (6), antidepressants, antipsychotics/neuroleptics and laxatives, presented with a history of one or two falls in the last three months, and presented with neuromuscular/functional and psychiatric or cognitive conditions. The total score was 17, indicating Resident #7 presented with a high risk for falls. The assessment documented to continue with the current plan of care; however failed to document an assessment for the safe use of the bolsters implemented on 5/17/16.	F 323		

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F 323	Continued From page 131 A rehabilitation screening form signed by the certified occupational therapy assistant on 12/6/16 documented, "Screen completed and patient not picked up in therapy. Pt currently on ST (speech therapy) caseload." A quarterly fall risk assessment dated 12/19/16 documented Resident #7 was presented with intermittent confusion, poor recall, judgement and safety awareness; presented with adequate vision, required the use of assistive devices (cane, walker or wheelchair), was ambulatory and incontinent, received anticoagulants, antidepressants, antipsychotics/neuroleptics and laxatives, presented with a history of one or two falls in the last three months, and presented with neuromuscular/functional and psychiatric or cognitive conditions. The total score was 17, indicating Resident #7 presented with a high risk for falls. The assessment documented to continue with the current plan of care; however failed to document an assessment for the safe use of the bolsters implemented on 5/17/16. A nurse's noted dated 1/25/17 documented, "A&O (Alert and Oriented) to self only with periods of agitation. Yelling out this AM (morning) while in bed. Attempted to get out of bed alone @ (at) 0900 (9:00 a.m.) and landed on his knees on the floor. No apparent injury. Resident agitated and was attempting to hit staff... (Name of physician) and RP/wife (name) notified..." A fall investigation dated 1/25/17 documented, "Resident attempted to get out of bed alone, crawled over bolsters, and landed on knees on floor. No apparent injury..." A unit manager's investigation report with an incident date of 1/25/17 documented, "RESIDENT ATTEMPTED	F 323		

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F 323	Continued From page 132 TO GET OUT OF BED ALONE. CRAWLED OVER BOLSTERS, AND WAS NOTED ON KNEES ON FLOOR. NO APPARENT INJURY NOTED..." Resident #7's comprehensive care plan with a problem start date of 1/6/17 documented, "Category: Falls- HIGH FALL RISK R/T CONFUSION; COMBATIVE BEHAVIOR; INCREASED ANXIETY; PSYCHOTROPIC MEDS; VISION LOSS; SEVERAL FALLS SICE ADMT...1/25- Resident found on floor (from bed) rolled over Bolsters- alarms going off. 0 app. (apparent) injury..." The care plan and the clinical record failed to document an assessment for the continued safe use of the bolsters for Resident #7. A post fall observation form completed on 1/31/17 by RN #1 documented Resident #7 fell in his room on 1/25/17. A description of the fall documented, "resident attempted to get out of bed alone, crawled over bolsters and landed on knees on floor." The form documented Resident #7 was in bed prior to the fall, the resident was alert with confusion, the resident was unable to ambulate and a bed pad alarm, fall alarm, fall mats and bilateral bolsters were in use at the time of the fall. The form further documented, "Describe measures to be taken to prevent further falls" No measures were documented. The post fall observation form failed to document an assessment for the safe use of the bolsters implemented on 5/17/16. Resident #7's May 2016 through February 2017 TARs (treatment administration records) documented, "bolsters to bilateral bedside at all times while in bed..."	F 323		

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F 323	Continued From page 133 On 2/22/17 at 9:25 a.m., bilateral bolsters were observed on Resident #7's bed. At this time, the resident was out of the room. On 2/22/17 at approximately 11:30 a.m. the survey team leader spoke with ASM (administrative staff member) #2 (the director of nursing) and requested a list of all residents who bolsters were being utilized for. The list revealed 16 residents had bed bolsters in place. On 2/22/17 at 1:30 p.m., this surveyor entered Resident #7's empty room. This surveyor pulled back the comforter, flat sheet and the fitted sheet on the resident's bed and was easily able to place an arm into and through the space between the middle of the bolster and the mattress while both ends of the bolster remained attached around the mattress. This surveyor removed her arm and placed the fitted sheet, flat sheet and comforter back into place around the bolster and mattress. On 2/22/17 at 2:20 p.m., Resident #7 was observed lying still in a low bed with bilateral bed bolsters. The resident's bed alarm was off and there was no fall mat present on the right side of the bed (note- the resident had a physician's order for a bed pad alarm and falls mats at bedside while in bed). On 2/22/17 at 3:50 p.m., Resident #7 was observed in a low bed with bilateral bed bolsters. The resident was observed moving his arms while attempting to remove his brief. The resident's feet were noted on the left side of the bed while the resident's upper body was positioned on the right side of the bed. The resident's bed alarm was off and there was no fall	F 323		

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F 323	Continued From page 134 mat present on the right side of the bed. On 2/22/17 at 5:22 p.m., an interview was conducted with ASM #2, the director of nursing and LPN (licensed practical nurse) #6 (a MDS coordinator). ASM #2 stated residents' fall risk is assessed starting at admission then quarterly and yearly. ASM #2 stated if a resident is at risk for falls or has a history of falls then interventions are implemented and the interventions are determined based on the facility falls prevention policy and procedure. ASM #2 stated when a resident falls, the nurse reports the fall to the physician and responsible party, implements an intervention and completes an incident report within 24 hours. ASM #2 stated the physician follows up with the incident report and the unit manager assesses the intervention for appropriateness and turns the report in to her (ASM #2). ASM #2 stated the fall is then discussed at the weekly risk management meeting and the interdisciplinary team discusses each resident's fall, the intervention that was implemented and whether the team thinks the intervention is a good idea or if the resident could benefit from a different intervention. When asked how the team decides if an intervention is appropriate, ASM #2 stated the decision is based on nursing judgement and individualized based on the resident. When asked if residents' interventions are routinely reassessed, ASM #2 stated residents who have fallen during the previous week are discussed at the risk management meeting and routine reassessments should be done quarterly at care plan meetings. ASM #2 and LPN #6 were asked the purpose of the bed bolsters. ASM #2 stated the purpose was to establish perimeters to keep residents	F 323		

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F 323	Continued From page 135 from falling out of bed. ASM #2 and LPN #6 were asked to review Resident #7's clinical record (including nurses' notes, fall risk assessments and post fall observations) from May 2016 through February 2017 and provide evidence that staff had conducted an assessment for the safe use of bed bolsters and reassessment after Resident #7 crawled over the bolsters and fell on 1/25/17; ASM #2 and LPN #6 were unable to provide this information. ASM #2 and LPN #6 were asked to provide the facility policy and procedure for operationalizing bolsters to include assessment of the safety and appropriateness for the use of bolsters and reassessment of bolster use after a fall. ASM #2 and LPN #6 were unable to verbalize a process or provide a policy. On 2/22/17 at 7:22 p.m., ASM #1 (the administrator) and ASM #2, the director of nursing were made aware of the above concerns. Resident #7 sustained a fall from the bed after crawling over the bed bolsters. Resident #7 had been observed in the bed with the bed bolsters in place and no bed alarm or fall mat in place per the physician's orders. The bed bolsters remained in place without any reassessment for safety and appropriateness of the bolsters implemented. The facility did not have a process or policy for the operationalization of the bolsters; no assessment for the appropriateness and safe use prior to implementation of the bed bolsters. The facility had no system for monitoring the use of and reassessment for safety and appropriateness of the bed bolsters. On 2/23/17 at 12:05 p.m., an interview was conducted with CNA (certified nursing assistant)	F 323		

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F 323	Continued From page 136 #7. CNA #7 was asked to describe her role in the determination of fall interventions for residents. CNA #7 stated if she walks into a room and a resident is trying to get out of bed then she suggests various interventions such as fall alarms, bed alarms, fall mats or a low bed to the nurse. CNA #7 stated nurses ultimately decide which interventions will be implemented. CNA #7 was asked when bed bolsters were considered. CNA #7 stated they would be considered when a resident keeps trying to throw his/her feet off the side of the bed or keeps trying to get up. When asked how staff determine if bolsters are safe and appropriate, CNA #7 stated staff usually makes sure the resident is safe by monitoring the resident to see if the resident is trying to climb out of the bed. When asked if she had ever been educated on bed bolsters prior to the survey, CNA #7 stated one person on that hall (the hall CNA #7 and this surveyor were standing in) was beginning the use of bolsters so CNA #28 (the medical records employee and the person who usually applied bolsters) showed her how to put the bolsters on. CNA #7 stated this occurred within the past year. CNA #7 was asked to describe the application of bolsters. CNA #7 stated, "A part runs on the bed frame; the bottom goes over, loops through the frame and goes back over and you Velcro down on two sides. Each side has a clip at the bottom and must clip." When asked if she had received any safety instructions regarding bolsters, CNA #7 stated she had not. When asked if the risks of residents climbing over the bolsters had been discussed, CNA #7 stated, "No. I don't think we discussed it." On 2/23/17 at 12:15 p.m., an interview was conducted with LPN #17, regarding the process	F 323		

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staff follows when a resident falls. LPN #17 stated the nurse should go in and assess the resident for any injuries, complete a fall incident report, and notify the physician and family. LPN #17 stated she might also send a referral to therapy for evaluation. When asked what type of interventions she would put in place for fall prevention, LPN #17 stated, "It depends on how the resident fell. If the resident fell out of bed, I might write an order for side rails." When asked about bed bolsters, LPN #17 stated bed bolsters keep the residents from falling out of the bed. LPN #17 stated staff would not order or place bolsters as a first intervention, but if a resident continued to fall out of bed, bolsters would be put into place. When asked how nursing would determine that bolsters were a safe and effective intervention for a resident, LPN #17 stated, "We would just put it on the bed. They are padded and cushioned." LPN #17 stated if the bolsters do not create a problem for the resident with positioning or if the resident does not attempt to crawl over the bolsters, then they should be a safe intervention to use. When asked if residents are assessed for safety prior to the bolsters being put into place, LPN #17 stated, "Yes." When asked how nursing assesses for the safe use of bolsters or where this assessment is documented, LPN #17 stated, "We would discuss with the unit manager and therapy. Most of the time we consult with therapy." LPN #17 was not sure if therapy assessed a resident for the use of bolsters. When asked about the potential risks of using bolsters, LPN #17 stated that the resident could climb over them. When asked who applies the bolsters to the bed, LPN #17 stated that the nursing staff applied bed bolsters. When asked how to safely apply bed bolsters, LPN #17 stated, "It comes with straps that are Velcro and the

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straps go under the bed and come back over the bed. There are directions that show how to tighten." When asked if any monitoring was conducted after bed bolsters were put into place, LPN #17 stated, "We look at the bed every shift but we don't monitor every 30 minutes." When asked what nursing is looking for and checking off on the TAR (treatment administration record) for bed bolsters, LPN #17 stated, "We are signing that the bed bolsters are intact on the bed."

On 2/23/17 at 12:20 p.m., an interview was conducted with CNA #40 (a restorative CNA [a CNA who provided exercises and other activities of daily living to maintain residents' level of functioning]). CNA #40 was asked when bed bolsters would be considered for residents. CNA #40 stated staff would try bed alarms and fall mats but if they didn't work then staff would try bolsters. CNA #40 stated bolsters worked most of the time but a few residents could get over them. When asked the purpose of the bed bolsters, CNA #40 stated it was to keep residents from coming out of the bed. When asked if she had ever been educated on the use of bed bolsters prior to survey, CNA #40 stated she already knew how to apply them. CNA #40 stated therapy staff or nurses show CNAs how to put bolsters on beds if needed and if staff does not know how to apply them. CNA #40 stated she "didn't deal with them much." When asked to describe what should be done each day to monitor bed bolsters, CNA #40 stated the bolsters should be checked to make sure they aren't loose and everything is hooked up the way it should be. When asked if she had received any in-services related to bed bolsters, CNA #40 stated she had not but the nurses could show staff how they work. At this time, CNA #40 was asked to

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accompany this surveyor to an empty resident room and show this surveyor how to apply bolsters. CNA #40 obtained a set of bolsters and accompanied this surveyor to an empty resident room. CNA #40 stated she puts the bolsters on then the fitted and flat sheets fit over top of the bolsters. CNA #40 was asked to provide a demonstration. CNA #40 removed the comforter and sheets from the bed, placed a bolster midways the length of the bed on each side of the bed, ran two straps that attached each bolster across the width of the bed mattress from one bolster to another and attached the bolsters together with the straps; then CNA #40 ran a strap attached to the outside of each bolster around the bed frame, brought the strap to a plastic fastener buckle with two parts; one part that slid into the second part and required a squeezing action on both sides to release it (similar to the buckle on a life vest). At this time, this surveyor placed one arm in between one of the bolsters and the mattress and raised the middle of the bolster approximately five inches while both ends of the bolster remained attached around the mattress. This surveyor removed the one arm. CNA #40 attempted to tighten the strap with the plastic fastener buckle and stated, "You gotta have it tight so it won't come up." At this time, this surveyor placed one arm in between the same bolster and mattress and raised the middle of the bolster approximately three inches while both ends of the bolster remained attached around the mattress. CNA #40 stated, "That's how it goes." CNA #40 agreed a resident could easily get a limb caught in the space between the bolster and the mattress.

On 2/23/17 at 12:30 p.m., an interview was conducted with RN (Registered Nurse) #7

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regarding falls. RN #7 stated that falls were discussed in risk management meetings once a week. RN #7 stated that the nurse who was present during a fall would implement an intervention and then this would be discussed in the risk management meetings to determine if the intervention was appropriate. When asked at what point bolsters would be put into place, RN #7 stated that she could not give a generic answer because interventions that are put into place are different for each individual. RN #7 stated that bolsters would be put into place if the resident benefited from them. When asked how nursing determined if bolsters were safe and appropriate for a resident, RN #7 stated, "I don't know. Based upon the resident's reactions because you don't know how a resident is going to respond to it. It's case by case." When asked what risks are associated with bolster use, RN #7 stated, "The resident could get caught up in it or crawl over them. I don't think it's a restraint of any kind." When asked how to safely apply bed bolsters, RN #7 stated, "(Name of CNA #28) puts them on during the day. I don't really put them on because my residents are usually out of bed during the day." When asked if there was a manual or directions on how to apply bed bolsters, RN #7 stated, "I don't know about education." When asked what it meant on the TAR (treatment administration record) when nursing was signing off that bed bolsters were in place, RN #7 stated, "That is just an FYI (for your information) the resident uses bed bolsters."

On 2/23/17 at 12:46 p.m., an interview was conducted with CNA #28 (the medical records employee). CNA #28 stated that she buys the bed bolsters for the facility and applies some of them to the beds. CNA #28 stated that the other

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the process. When asked if the risk management team was responsible for ensuring policies and procedures for these matters were in place for nursing staff, RN #1 stated, "Yes." In regards to the purpose of the post fall observation forms that RN #1 had completed, RN #1 stated she completes the forms to see if the nursing staff followed up with prevention and to make sure an intervention was implemented. RN #1 stated she reviews the physician order for the intervention, asks the unit manager if the intervention has been put in place but does not look to see if the intervention is safe or in place.

On 2/23/17 at 3:17 p.m., ASM #2, the director of nursing stated the risk management committee had met and decided bolsters would no longer be used in the facility. The director of nursing stated the bolsters were removed from the facility.

The bolster manufacturer's instructions termed the name of the device as a "roll control bolster." The manufacturer's instructions documented, "A safe alternative to side rails, Roll-Control Bolsters help prevent falls from rolling out of bed. The adjustable bolster attaches to the bed with quick-release buckles and may be repositioned to accommodate individual patient needs. While providing sufficient space for patient comfort, the bolster is not considered a restraint for most patients. Roll control bolsters can be added to help reduce potential bed rail entrapment zones. Made with comfortable foam padding and covered in a durable wipe clean vinyl cover...Dimensions: 34 "L (length) x (by) 7" H x 8" D. APPLICATION INSTRUCTIONS: 1. Place the bolsters on the bed as shown in the picture in figure 1. 2. For both bolsters, bring the end of the strap under and around the upper movable part of

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the bed frame and secure the quick-release buckle, as shown in figure 2. Tighten strap, making certain that the bolster is positioned near or at the edge of the mattress. Do not secure the strap to the side rail. 3. Thread the Velcro straps attached to one bolster through the D-rings at the opposite bolster, as shown in figure 3. Bring the straps over the bolster and thread them through the D-rings at the back of the bolster. Take up any slack in the Velcro strap and secure them by pressing the 'hook' material against the 'loop' material, as shown in figure 4. 4. To modify the distance between the bolsters, re-adjust the straps in step 3 to the desired position on the bed. 5. For patient comfort, cover the straps that cross the bed with a folded sheet or synthetic sheepskin pad..."

On 2/23/17 at 3:32 p.m., this surveyor called the phone number listed on the bolster manufacturer's instructions to obtain further information regarding the safe use of bolsters including application, daily use, monitoring and risks. The office manager stated all questions needed to be submitted via email and would be forwarded to the director of the company.

On 2/27/17 at 1:37 p.m., an interview was conducted with OSM #5 (the therapy/rehab [rehabilitation] program manager/physical therapist). OSM #5 was asked to describe the role the therapy department played in a resident's care after a fall. OSM #5 stated the therapy department is notified of each fall through a referral slip or via the risk management meetings. OSM #5 stated once the therapy department is notified that a resident has fallen, she has a therapist complete a screen to see if there is something the therapy department can work on (if

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the resident would benefit from therapy). OSM #5 stated if the screen determines the resident would not benefit from therapy then the next step is to "work on safety interventions with nursing like floor mats." OSM #5 stated she usually lets the nursing staff know the resident is not a candidate for rehab then the nursing staff decides on the interventions. OSM #5 stated sometimes the physical therapists may make suggestions but it is the responsibility of nursing staff to assess the intervention to see if it is safe for the resident. At this time, OSM #5 confirmed she didn't play any role in the assessment of the safety of bolsters for residents. OSM #5 stated sometimes the therapy department receives a referral to look at residents for positioning. OSM #5 stated in that case therapy staff would assess the appropriateness of the devices including bolsters if the resident had them. When asked how the therapy staff assesses bolsters to determine appropriateness, OSM #5 stated she wasn't sure if the therapy staff had ever assessed a resident for positioning related to bolsters but if they did, they would assess the resident for safety and make sure the bolsters were safe. When asked how that safety assessment would be conducted, OSM #5 stated that was hard for her to answer because the occupational therapist would be the person to complete the assessment. During this interview, OSM #5 was asked what she would recommend if a resident crawled over a bolster. OSM #5 stated she would recommend the removal of the bolsters. OSM #5 stated, "It's really not doing anything if they are climbing over and falling."

On 2/27/17 at 2:20 p.m., an interview was conducted with OSM #2 (an occupational therapist). OSM #2 was asked to describe the

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role he played in a resident's care after a fall. OSM #2 stated his department head attends meetings and once those meetings occur, the therapy staff is asked to complete screens. OSM #2 stated screens are also completed each quarter. When asked to describe a screen, OSM #2 stated a screen can be done by any one of the three therapy disciplines (physical therapy, occupational therapy or speech therapy) and is completed for all three disciplines. OSM #2 stated the screen consists of taking a look at the individual and getting an idea of what the individual's needs are and what the therapy department can provide. OSM #2 stated the screen consists of observation of the resident and asking the nursing department questions but does not include hands on physical interaction because at that point there is no physician's order for the therapists to treat the resident. OSM #2 stated the screen determines if there is nothing the therapy department can do for the resident or if the resident will benefit from therapy and if so, a physician's order to treat is obtained. OSM #2 was asked if he plays a role in the assessment of fall prevention devices. OSM #2 stated he notes the devices that are implemented when he completes a screen but he wasn't sure if the appropriateness of the device was discussed at that time. OSM #2 stated discussion of the appropriateness of fall prevention devices could verbally occur but not documented on a form. OSM #2 stated referral forms appear on his desk or the therapy director comes to him. When asked if he is verbally told the interventions in place for that resident and discusses the safety of those interventions, OSM #2 stated, "I don't think that comes up very much or at all." When asked the importance of an assessment of the relevance of interventions, OSM #2 stated this

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was importance and he notes the resident's behaviors, diagnoses, if the person is static (unable to move) or dynamic (able to move) because positioning is different for a static person as opposed to a dynamic person. When asked to provide an example of how this thought process occurs related to assessing the appropriateness of an intervention, OSM #2 stated for a static person, he looks at basic physics and some static people slide in their seat so strategies that increase friction such as a built up cushions are used. OSM #2 stated for residents who are dynamic, he assesses their safety awareness and posture in wheelchairs to see if they are aware and able to respond in order to correct their balance. OSM #2 was asked if this type of thought process occurred when nurses implemented interventions/devices. OSM #2 stated he didn't think that "fine tuning" occurred and he thought a lot of times nurses think, "That worked for Ms. X so it may work for Ms. Y." OSM #2 stated the therapy staff takes a look at the "whole picture." OSM #2 was asked the purpose of bolsters (termed bilateral bed wedges or bed ramps by OSM #2). OSM #2 stated the bolsters were used to assist with safety for people who can inadvertently roll out of bed. OSM #2 stated he looks at the ability of the resident and if the bolster is flesh with the mattress. When asked if there were any risks for residents trying to get out of bed with bolsters in place, OSM #2 stated he didn't know if they were any more dangerous than a bedrail because it was an obstacle. OSM #2 stated staff must complete trial and error to see what works for residents. When asked if staff conducts conversations to discuss whether interventions such as fall mats and bolsters are safe for residents, OSM #2 stated the staff did not. OSM #2 was asked if there was a discussion

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held regarding the safe use of bolsters for Resident #7. OSM #2 stated he knew therapy staff had periodically looked at the resident and there was no variation in his condition. When asked if he had any discussions with other staff regarding the safe use of bolsters for Resident #7, OSM #2 stated he had not.

On 2/27/17 at 4:43 p.m., an interview was conducted with ASM #3 (Resident #7's physician). ASM #3 was asked to describe her role in the implementation of fall interventions. ASM #3 stated she usually receives a recommendation and she says yes it's a good idea or it's not a good idea. ASM #3 stated sometimes she asks the physical therapy department for recommendations regarding devices. ASM #3 was asked to describe her assessment as to whether bolsters are a good idea for residents. ASM #3 stated she is generally not the physician on call because she is the "house" physician. ASM #3 stated if staff asks to implement bolsters or if she has recommended bolsters then she has seen the resident to decide if that's a valid recommendation. ASM #3 stated she has usually seen good results with bolsters regarding residents who are bed bound and don't roll or turn. ASM #3 was asked if she attended the risk management meetings. ASM #3 stated she did every week. ASM #3 was asked if there were discussions about fall interventions and the validity of the interventions for each resident. ASM #3 stated, "Yes and if we need to change (the interventions) we talk about it." ASM #3 was asked if the risk management team discusses the safety and effectiveness of fall interventions. ASM #3 stated this was discussed only if there was an issue. When asked if a discussion should

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F 323	Continued From page 148 be held if a resident crawls over a bed bolster, ASM #3 stated, "We usually talk about that." ASM #3 was asked if she was aware Resident #7 continued with bolsters in place despite the resident having crawled over the bolsters and falling from the bed on 1/25/17. ASM #3 stated she didn't recall any information off the top of her head. ASM #3 stated Resident #7 was not a resident staff would expect to crawl out of bed. When asked if the need for bolsters should have been reassessed after Resident #7 crawled over them, ASM #3 stated, "I would agree with that." When ASM #3 was asked if the reassessment of the bolsters should have been a function of the risk management team, ASM #3 stated, "Yeah." On 2/27/17 at 5:50 p.m., this surveyor confirmed with ASM #1, the administrator, and ASM #2, the director of nursing, that prior to the survey the facility staff had no process for the assessment for safe use of the bolsters and for or for the operationalization of the bolsters. ASM #1 and ASM #2 also confirmed the facility had not evaluated the bolsters for risk of resident entrapment. ASM #2, the director of nursing stated the bolsters had been in the building for "a while" and were used as more of a positioning device. When asked to clarify whether the bolsters were used as fall interventions (as documented in some residents' clinical records) or for positioning, ASM #2 stated the bolsters were used for both purposes and also for seizure precautions. ASM #2 stated the bolsters were implemented in the facility prior to her position as director of nursing. On 2/28/17 at 9:35 a.m., RN #5 was interviewed regarding Resident #7's mobility status. RN #5	F 323		

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F 323	Continued From page 149 stated the resident usually required moderate to maximum assistance with the exception of episodes of agitation. RN #5 stated the resident was able to move all extremities. On 2/28/17 at 2:51 p.m., an interview was conducted with RN #5. RN #5 was asked to clarify if a concave mattress had ever been implemented for Resident #7. RN #5 stated she would have to research this information. At this time, RN #5 confirmed that prior to the survey the facility staff had no process to assess each resident's use of bolsters for safety risks. RN #5 stated the decision as to what fall interventions were implemented for residents was based on nursing judgement and fall assessments. RN #5 stated the fall assessments contained a section at the bottom of the form to document referrals, suggestions or an option to continue the current plan of care; however didn't speak to a safety assessment for the use of the bolsters. On 2/28/17 at 3:21 p.m., RN #5 returned to this surveyor and stated she didn't see any documentation of or orders for Resident #7 having a concave mattress. The facility document titled "FALLS POLICY" updated on 1/25/17 documented, "FALLS ARE DISCUSSED PER RISK MANAGEMENT MEETING WEEKLY. UNIT MANAGER WILL COMPLETE UNIT MANAGER UPDATE ON FALLS, AND ANY INCIDENT TO THE DON AND ADMINISTRATOR..." The facility document titled, "FALLS PREVENTION POLICY AND PROCEDURE" dated 1/25/17 documented, "UPON ADMISSION RESIDENTS ARE EVALUATED FOR RISKS OF FALLS AND HISTORY OF FALLS. FALL RISK ASSESSMENTS ARE COMPLETED UPON	F 323		

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F 323	Continued From page 150 ADMISSION AND QUARTERLY. IF A RESIDENT IS DEEMED A HIGH RISK OF FALLS PEVENTATIVE DEVICES ARE PLACED. FACILITY FALL PREVENTATIVE DEVICES ARE: FALL ALARM, BED PAD ALARM, CHAIR PAD ALARM, LOW BED WITH FALL MATS, AND BOLSTERS." The facility document titled, "Assistive Devices to Prevent Falls" (no date) documented, "Policy: Facility is to use the least restrictive device for preventing fall in high risk residents. Procedure: 1. Upon admission to facility nursing is to complete a fall risk assessment to determine fall risk. If score warrants a device nursing is to apply least restrictive device available. Equipment currently available are (sic) the following...Wedge applied to chair or bed to aid in positioning...2. Rehabilitation Department to screen/evaluate resident at earliest opportunity for appropriate assistive device in preventing falls. 3. Resident to be reviewed by risk management committee for effectiveness of physical devices and quarterly by QA committee." The facility document titled, "Policy for Completion of Incident Report" (no date) documented, "When a resident fall (sic) his/her charge nurse fills out an incident report, then the charge nurse implements a (sic) intervention, writes order for the intervention, then the charge nurse ensures that the intervention was carried out. Charge nurse notifies M.D. (medical doctor) and R.P. (responsible party) the incident report is placed on M.D. communication board for signature. Post M.D. signature, unit managers circulate signed reports to DON (director of nursing), ADON (assistant director of nursing), restorative nurse, MDS coordinator and assistant,	F 323		

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both unit managers, therapy department, and QA (quality assurance) nurse. After original is signed by DON, the Administrator (sic) for signatures then they are turned back in to QA nurse. Resident is reviewed at the weekly risk management meeting for effectiveness of intervention that was implemented."

The facility document titled, "Assistive Devices For Positioning" (no date) documented, "Policy: Facility is to use the least restrictive device for positioning in high risk residents. Procedure: 1. Upon admission to facility nursing is to determine if positioning device is warranted. 2. Rehabilitation Department to screen/evaluate resident at earliest opportunity for appropriate assistive device for positioning. 3. Resident to be reviewed quarterly by Occupational Therapy Department for effectiveness of physical devices. Devices currently available are the following...Wedge applied to chair or bed to aid in positioning..."

The facility document titled, "Risk Management Meetings" (no date) documented, "Day/Time: Meetings will be held every week on Wednesday @ 1:30 pm. Meetings should last 30-45 minutes at max (maximum). All members of the Risk Management Meeting are expected to attend meetings. Members should come prepared and arrive on time. Meeting Agenda/Responsibilities...Falls: Discuss residents who fell during the previous week and explore new interventions to prevent/reduce further falls, as wells as, follow-up on efficiency on interventions already in place. Discuss residents that are at a high risk for falls and the efficiency/benefits of the interventions already in place for their individual needs. (Name of RN #1)

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F 323	Continued From page 152 (or name of RN #5) will gather the fall data (including the incident reports). Give fall data to (name of another employee) to type up...Members of the Risk Management Committee: (name and title of) Director of nursing North unit manager South unit manager Admissions Activities Therapy/rehab program manager Dietary manager MDS coordinator MDS coordinator Assistant director of nursing/quality assurance nurse." On 2/27/17 at 5:50 p.m. an end of the day meeting was conducted with ASM #1, the administrator, ASM #2, the director of nursing, LPN #2, the north wing unit manager, OSM (other staff member) #4, the dietary manager, OSM #7, the business manager and OSM #1, the director of maintenance. The administrative staff was made aware of the concern and stated that there was no further information that they could provide. No further information was presented prior to the end of the survey. (1) "Lewy body disease is one of the most common causes of dementia in the elderly. Dementia is the loss of mental functions severe enough to affect normal activities and relationships. Lewy body disease happens when abnormal structures, called Lewy bodies, build up in areas of the brain..." This information was obtained from the website:	F 323		

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F 323	Continued From page 153 https://medlineplus.gov/lewybodydisease.html (2) "Parkinson's disease (PD) is a type of movement disorder. It happens when nerve cells in the brain don't produce enough of a brain chemical called dopamine..." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=parkinson%27s+disease (3) "Antidepressants are medicines that treat depression..." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=antidepressants (4) "Antipsychotic medicines (also known as neuroleptics) are primarily used to manage psychosis. The word "psychosis" is used to describe conditions that affect the mind, and in which there has been some loss of contact with reality, often including delusions (false, fixed beliefs) or hallucinations (hearing or seeing things that are not really there)..." This information was obtained from the website: https://www.nimh.nih.gov/health/topics/mental-health-medications/index.shtml (5) Laxatives are medications used to treat constipation. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000120.htm (6) Anticoagulants are medications used to thin the blood. This information was obtained from	F 323		

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F 323	Continued From page 154 the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=anticoagulants&_ga=1.64699887.139120270.1477942321 b. The facility staff failed to implement Resident #7's bed alarm and fall mats per physician's orders. Review of Resident #7's clinical record revealed a physician's order summary signed by the physician on 1/13/17 that documented orders for a bed pad alarm and fall mats at bedside while the resident was in bed. Resident #7's comprehensive care plan with a problem start date of 1/6/17 documented, "HIGH FALL RISK R/T (related to) CONFUSION; COMBATIVE BEHAVIOR; INCREASED ANXIETY; PSYCHOTROPIC MEDS (medications); VISION LOSS; SEVERAL FALLS SINCE ADMIT...Approach: BED/FALL ALARMS ON PER ORDER; MONITOR RESIDENT FOR TAKING ALARMS OFF AND REPLACE AS NEEDED; ENSURE THE ALARM IS IN GOOD WORKING ORDER AND TURNED ON; CHANGE BATTERIES AS NEEDED; FALL MATS BESIDE BED AS ORDERED..." On 2/22/17 at 2:20 p.m. and 3:50 p.m., Resident #7 was observed lying in bed. The resident's bed alarm was off and there was no fall mat present on the right side of the bed. On 2/22/17 at 4:40 p.m., an interview was conducted with CNA (certified nursing assistant)	F 323		

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F 323	Continued From page 155 #3 (the CNA caring for Resident #7). CNA #3 was asked how she was made aware of the safety devices required for each resident. CNA #3 stated the nurse will pass that information on to the CNAs and the CNAs have a book they can reference that includes which residents should have fall alarms, bed alarms and fall mats. CNA #3 was asked which safety devices were supposed to be implemented for Resident #7. CNA #3 stated the resident was supposed to have a clip fall alarm, bed pad alarm, bolsters, a pommel cushion wedge in the chair and fall mats. When made aware Resident #7 was observed in bed twice with the alarm off and the fall mat not on the floor, CNA #3 stated prior to this interview she had noted the resident was yelling and had slid off the pillow and his body wasn't aligned in the bed. CNA #3 stated during this time, the resident's bed pad alarm was not sounding. CNA #3 further stated she didn't recall picking the resident's fall mat up off the floor when she got the resident out of bed. On 2/27/17 at 3:44 p.m., an interview was conducted with RN (registered nurse) #5. RN #5 was asked how nursing staff was made aware of the safety devices required for each resident. RN #5 stated the nursing staff is notified as soon as a device is implemented, discontinued or changed. RN #5 stated sign-off books for devices were located at the nurse's station and regularly updated. On 2/27/17 at 5:50 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "FALLS POLICY"	F 323		

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F 323	Continued From page 156 documented, "IF A RESIDENT IS DEEMED A HIGH RISK OF FALLS PREVENTATIVE DEVICES ARE PLACED. FACILITY FALL PREVENTATIVE DEVICES ARE: FALL ALARM, BED PAD ALARM, CHAIR PAD ALARM, LOW BED WITH FALL MATS, AND BOLSTERS..." No further information was presented prior to exit. 2. Resident #14 fell on 10/7/16 and the facility placed bed bolsters on the resident's bed without any assessment for the safe use of the bed bolsters as an intervention for Resident #14. On 12/1/16 Resident #14 was observed sitting on the fall mat beside the bed (the bed bolsters had been moved). On 12/27/16 Resident #14 was observed on the fall mat beside the bed. On 2/14/17 Resident #14 attempted to crawl over the bed bolster while attempting to get out of bed and slid to the floor mat. The facility staff failed to reassess the safe use of bed bolsters after each fall. Resident #14 was admitted to the facility on 5/2/13 and readmitted to the facility on 7/31/15. Resident #14's diagnoses included but were not limited to: Parkinson's disease (1), dementia (2) and insomnia (3). Resident #14's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/6/17 coded the resident as being cognitively intact, scoring a 13 out of a possible 15 on the brief interview for mental status. Section G coded Resident #14 as requiring extensive assistance of two or more staff with bed mobility and transfers. A nurse's note dated 10/7/16 documented,	F 323		

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F 323	Continued From page 157 "Resident on follow up for bruising noted to bilateral knees after being observed on knees on fall mat previously during the am. Denies any pain or discomfort, Vital signs WNLs (within normal limits). MD (medical doctor) and RP (responsible party) (daughter) aware of the above. New orders received for Bolsters QHS (every hour of sleep) today. Daughter aware of intervention in place." A fall investigation dated 10/7/16 documented, "Resident off of low bed on fall mat on her knees. ROM (Range of motion) to all 4 exts (extremities) WNLs. Denies any pain or discomfort. Observed in an upright position. Stated, 'I slid off the side.' Action taken: (a check mark beside) Other-Bolsters to bed QHS (every bedtime)..." A unit manager's investigation report with an incident date of 10/7/16 documented, "Resident off of low bed on fall mat on her knees. ROM x (times) 4 extremities (sic) WNLs. Denies any pain or discomfort. Observed in an upright position. Stated, 'I slid off the side..." Resident #14's comprehensive care plan with a problem start date of 7/12/16 documented, "10/7- Resident fell. 0 (No) inj. (No injury)...10/7- Bil (Bilateral) Bolsters to bed..." The care plan and the clinical record failed to document an assessment for the safe use of the bolsters implemented for Resident #14. A physician's order dated 10/7/16 documented, "Bolsters to bilateral bedside at all times while in bed." A fall risk assessment dated 10/9/16 documented Resident #14 presented with intermittent confusion, poor recall, judgment and safety awareness; presented with adequate	F 323		

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F 323	Continued From page 158 vision; required the use of assistive devices (cane, walker or wheelchair), presented with impaired mobility and was continent, received antidepressants, laxatives and hypnotic (sleep) medications; presented with a history of one or two falls in the last three months, and presented with neuromuscular/functional and psychiatric or cognitive conditions. The total score was 15, indicating Resident #14 presented with a high risk for falls. The "PLAN OF CARE" section documented, "Continue Current Plan of Care." A nurse's note dated 12/1/16 documented, "Resi (Resident) sitting on side of bed at 2310 (11:10 p.m.) while administering medication. After several requests, resi refused to lay down stating, 'I'm not ready yet.' All safety precautions in place and functioning properly at that time. Resi found sitting on fall mat beside bed at 0030 (12:30 a.m.) having removed FA (fall alarm), disengaged BPA (bed pad alarm) and removed bolster..." A fall investigation dated 12/1/16 documented, "Resi found sitting on fall mat beside bed- FA (fall alarm), BPA (bed pad alarm) had been removed disengaged- bolster moved..." A unit manager's investigation report with an incident date of 12/1/16 documented, "RESIDENT FOUND SITTING ON FALL MAT BESIDE BED- FA, BPA, HAD BEEN REMOVED AND DISENGAGED BY RESIDENT. BOLSTERS REMOVED..." A post fall observation form completed on 12/6/16 by RN (registered nurse) #1 (the quality assurance nurse/assistant director of nursing) documented Resident #14 fell in her room on 12/1/16. A description of the fall documented, "Resident found sitting on fall mats on floor beside bed, fall alarm and bed pad alarm had been removed and disengaged. Bolsters removed." The form documented Resident #14 was in bed prior to the	F 323		

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F 323	Continued From page 159 fall, the resident was alert with confusion, the resident was unable to ambulate and the resident was educated to prevent further falls. Resident #14's comprehensive care plan with a start date of 10/12/16 documented, "FALL RISK WITH POTENTIAL FOR INJURY; UNSTEADY BALANCE AND GAIT; AMBULATES WITH RESTORATIVE; WILL ATTEMPT TO TRANSFER SELF UNASSISTED; C/O (complains of pain) AT TIMES; NEEDS EXTENSIVE ASSIST WITH TRANSFERS...12/1- Fell. 0 injury...Approach: BED BOLSTERS TO BED AS ORDERED..." The care plan and the clinical record failed to document an assessment or reassessment for the safe use of the bolsters implemented for Resident #14. A nurse's note dated 12/27/16 documented, "resident (sic) found at bedside on fall mat, reside (sic) stated, slide (sic) out of the bed...no injury's (sic) or bruising noted..." A fall investigation dated 12/27/16 documented, "Right beside bed on the fall mat. Resident stated she slide (sic) down..." A unit manager's investigation with an incident date of 12/27/16 documented, "RIGHT BESIDE BED ON THE FALL MAT. RESIDENT STATED SHE SLIDE (sic) DOWN..." No post fall observation was documented. Resident #14's comprehensive care plan with a start date of 10/12/16 documented, "FALL RISK WITH POTENTIAL FOR INJURY; UNSTEADY BALANCE AND GAIT; AMBULATES WITH RESTORATIVE; WILL ATTEMPT TO TRANSFER SELF UNASSISTED; C/O (complains of pain) AT TIMES; NEEDS EXTENSIVE ASSIST WITH TRANSFERS...12/27- Fell in room. 0 inj...Approach: BED BOLSTERS TO BED AS ORDERED..." The care plan and the clinical record failed to document an assessment or	F 323		

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reassessment for the safe use of the bolsters implemented for Resident #14.

A nurse's note dated 2/14/17 documented, "Resi (Resident) attempting to get OOB (out of bed) and transfer per resi, slid to floor mat, going over bolster in place to side of bed. Resi had removed FA (fall alarm), bed pad alarm sounding. No c/o (complaint of) pain voiced when questioned..." A fall investigation dated 2/14/17 documented, "Resi attempting to transfer OOB without staff assistance slid to floor mat- No s/sx (signs or symptoms) of injury..." A unit manager's investigation with an incident date of 2/14/17 documented, "BPA (Bed pad alarm) SOUNDING, RESIDENT HAD REMOVED FA. RESIDENT ATTEMPTED TO TRANSFER SELF OOB WITHOUT STAFF ASSISTANCE AND SLID TO FLOOR MAT..." A post fall observation form completed on 2/16/17 by RN (registered nurse) #1 documented Resident #14 fell in her room on 2/14/17. A description of the fall documented, "Resident attempting to transfer out of bed without assistance, slid to floor mat." The form documented Resident #14 was in bed prior to the fall, the resident was alert with confusion, the resident required assistance with ambulation, and a bed pad alarm, fall alarm, fall mats and bed bolsters were in use. Resident #14's comprehensive care plan with a start date of 1/10/17 documented, " HIGH FALL RISK WITH POTENTIAL FOR INJURY DUE TO DX (diagnosis) OF OSTEOPOROSIS; WEARS GLASSES AND HAS ADEQUATE VISION WITH USE; UNSTEADY BALANCE AND GAIT; AMBULATES WITH ASSISTANCE; NONCOMPLIANT WITH ASKING AND WAITING FOR ASSISTANCE FROM STAFF; WILL ATTEMPT TO TRANSFER SELF

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F 323	Continued From page 161 UNASSISTED...2/14- Resident fell while trying to transfer self. 0 inj...Approach: BED BOLSTERS TO BED AS ORDERED..." The care plan and the clinical record failed to document an assessment or reassessment for appropriateness /safety for the continued use of the bed bolsters implemented for Resident #14. Resident #14's TARs (treatment administration records) from October 2016 through February 2017 documented, "Bolsters to bilateral bedside at all times while in bed." Further review of Resident #14's clinical record failed to reveal occupational therapy notes and revealed physical therapy notes for dates of service from 12/12/16 through 1/12/17. Review of the physical therapy notes failed to reveal documentation regarding bed bolsters. On 2/22/17 at 5:22 p.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing and LPN (licensed practical nurse) #6 (a MDS coordinator). ASM #2 stated residents' fall risk is assessed starting at admission then quarterly and yearly. ASM #2 stated if a resident is at risk for falls or has a history of falls then interventions are implemented and the interventions are determined based on the facility falls prevention policy and procedure. ASM #2 stated when a resident falls, the nurse reports the fall to the physician and responsible party, implements an intervention and completes an incident report within 24 hours. ASM #2 stated the physician follows up with the incident report and the unit manager assesses the intervention for appropriateness and turns the report in to her (ASM #2). ASM #2 stated the fall is then	F 323		

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F 323	Continued From page 162 discussed at the weekly risk management meeting and the interdisciplinary team discusses each resident's fall, the intervention that was implemented and whether the team thinks the intervention is a good idea or if the resident could benefit from a different intervention. When asked how the team decides if an intervention is appropriate, ASM #2 stated the decision is based on nursing judgement and individualized based on the resident. When asked if residents' interventions are routinely reassessed, ASM #2 stated residents who have fallen during the previous week are discussed at the risk management meeting and routine reassessments should be done quarterly at care plan meetings. ASM #2 and LPN #6 were asked the purpose of the bed bolsters. ASM #2 stated the purpose was to establish perimeters to keep residents from falling out of bed. ASM #2 and LPN #6 were asked to provide evidence that staff had conducted an assessment for the safe use of bed bolsters and reassessment after Resident #14 attempted to crawl over the bed bolsters on 2/14/17; ASM #2 and LPN #6 were unable to provide this information. ASM #2 and LPN #6 were asked to provide the facility policy and procedure for operationalizing bolsters to include assessment of the safety and appropriateness for the use of bolsters. ASM #2 and LPN #6 were unable to verbalize a process or provide a policy. On 2/23/17 at 12:05 p.m., an interview was conducted with CNA (certified nursing assistant) #7. CNA #7 was asked to describe her role in the determination of fall interventions for residents. CNA #7 stated if she walks into a room and a resident is trying to get out of bed then she suggests various interventions such as fall alarms, bed alarms, fall mats or a low bed to the	F 323		

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nurse. CNA #7 stated nurses ultimately decide which interventions will be implemented. CNA #7 was asked when bed bolsters were considered. CNA #7 stated they would be considered when a resident keeps trying to throw his/her feet off the side of the bed or keeps trying to get up. When asked how staff determine if bolsters are safe and appropriate, CNA #7 stated staff usually makes sure the resident is safe by monitoring the resident to see if the resident is trying to climb out of the bed. When asked if she had ever been educated on bed bolsters prior to the survey, CNA #7 stated one person on that hall (the hall CNA #7 and this surveyor were standing in) was beginning the use of bolsters so CNA #28 (the medical records employee and the person who usually applied bolsters) showed her how to put the bolsters on. CNA #7 stated this occurred within the past year. When asked if she had received any safety instructions regarding bolsters, CNA #7 stated she had not. When asked if the risks of residents climbing over the bolsters had been discussed, CNA #7 stated, "No. I don't think we discussed it."

On 2/23/17 at 12:15 p.m., an interview was conducted with LPN #17, regarding the process staff follows when a resident falls. LPN #17 stated the nurse should go in and assess the resident for any injuries, complete a fall incident report, and notify the physician and family. LPN #17 stated she might also send a referral to therapy for evaluation. When asked what type of interventions she would put in place for fall prevention, LPN #17 stated, "It depends on how the resident fell. If the resident fell out of bed, I might write an order for side rails." When asked about bed bolsters, LPN #17 stated bed bolsters keep the residents from falling out of the bed.

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F 323	Continued From page 164 LPN #17 stated staff would not order or place bolsters as a first intervention, but if a resident continued to fall out of bed, bolsters would be put into place. When asked how nursing would determine that bolsters were a safe and effective intervention for a resident, LPN #17 stated, "We would just put it on the bed. They are padded and cushioned." LPN #17 stated if the bolsters do not create a problem for the resident with positioning or if the resident does not attempt to crawl over the bolsters, then they should be a safe intervention to use. When asked if residents are assessed for safety prior to the bolsters being put into place, LPN #17 stated, "Yes." When asked how nursing assesses for the safe use of bolsters or where this assessment is documented, LPN #17 stated, "We would discuss with the unit manager and therapy. Most of the time we consult with therapy." LPN #17 was not sure if therapy assessed a resident for the use of bolsters. When asked about the potential risks of using bolsters, LPN #17 stated that the resident could climb over them. When asked who applies the bolsters to the bed, LPN #17 stated that the nursing staff applied bed bolsters. When asked how to safely apply bed bolsters, LPN #17 stated, "It comes with straps that are Velcro and the straps go under the bed and come back over the bed. There are directions that show how to tighten." When asked if any monitoring was conducted after bed bolsters were put into place, LPN #17 stated, "We look at the bed every shift but we don't monitor every 30 minutes." When asked what nursing is looking for and checking off on the TAR (treatment administration record) for bed bolsters, LPN #17 stated, "We are signing that the bed bolsters are intact on the bed." On 2/23/17 at 12:20 p.m., an interview was	F 323		

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conducted with CNA #40 (a restorative CNA [a CNA who provided exercises and other activities of daily living to maintain residents' level of functioning]). CNA #40 was asked when bed bolsters would be considered for residents. CNA #40 stated staff would try bed alarms and fall mats but if they didn't work then staff would try bolsters. CNA #40 stated bolsters worked most of the time but a few residents could get over them. When asked the purpose of the bed bolsters, CNA #40 stated it was to keep residents from coming out of the bed. When asked if she had ever been educated on the use of bed bolsters prior to survey, CNA #40 stated she already knew how to apply them. CNA #40 stated therapy staff or nurses show CNAs how to put bolsters on beds if needed and if staff does not know how to apply them. CNA #40 stated she "didn't deal with them much." When asked to describe what should be done each day to monitor bed bolsters, CNA #40 stated the bolsters should be checked to make sure they aren't loose and everything is hooked up the way it should be. When asked if she had received any in-services related to bed bolsters, CNA #40 stated she had not but the nurses could show staff how they work. At this time, CNA #40 was asked to accompany this surveyor to an empty resident room and show this surveyor how to apply bolsters. CNA #40 obtained a set of bolsters and accompanied this surveyor to an empty resident room. CNA #40 stated she puts the bolsters on then the fitted and flat sheets fit over top of the bolsters. CNA #40 was asked to provide a demonstration. CNA #40 removed the comforter and sheets from the bed, placed a bolster midways the length of the bed on each side of the bed, ran two straps that attached each bolster across the width of the bed mattress from one

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bolster to another and attached the bolsters together with the straps; then CNA #40 ran a strap attached to the outside of each bolster around the bed frame, brought the strap to a plastic fastener buckle with two parts; one part that slid into the second part and required a squeezing action on both sides to release it (similar to the buckle on a life vest). At this time, this surveyor placed one arm in between one of the bolsters and the mattress and raised the middle of the bolster approximately five inches while both ends of the bolster remained attached around the mattress. This surveyor removed the one arm. CNA #40 attempted to tighten the strap with the plastic fastener buckle and stated, "You gotta have it tight so it won't come up." At this time, this surveyor placed one arm in between the same bolster and mattress and raised the middle of the bolster approximately three inches while both ends of the bolster remained attached around the mattress. CNA #40 stated, "That's how it goes." CNA #40 agreed a resident could easily get a limb caught in the space between the bolster and the mattress.

On 12/23/17 at 12:30 p.m., an interview was conducted with RN (Registered Nurse) #7 regarding falls. RN #7 stated that falls were discussed in risk management meetings once a week. RN #7 stated that the nurse who was present during a fall would implement an intervention and then this would be discussed in the risk management meetings to determine if the intervention was appropriate. When asked at what point bolsters would be put into place, RN #7 stated that she could not give a generic answer because interventions that are put into place are different for each individual. RN #7 stated that bolsters would be put into place if the

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resident benefited from them. When asked how nursing determined if bolsters were safe and appropriate for a resident, RN #7 stated, "I don't know. Based upon the resident's reactions because you don't know how a resident is going to respond to it. It's case by case." When asked what risks are associated with bolster use, RN #7 stated, "The resident could get caught up in it or crawl over them. I don't think it's a restraint of any kind." When asked how to safely apply bed bolsters, RN #7 stated, "(Name of CNA #28) puts them on during the day. I don't really put them on because my residents are usually out of bed during the day." When asked if there was a manual or directions on how to apply bed bolsters, RN #7 stated, "I don't know about education." When asked what it meant on the TAR (treatment administration record) when nursing was signing off that bed bolsters were in place, RN #7 stated, "That is just an FYI (for your information) the resident uses bed bolsters."

On 2/23/17 at 12:46 p.m., an interview was conducted with CNA #28 (the medical records employee). CNA #28 stated that she buys the bed bolsters for the facility and applies some of them to the beds. CNA #28 stated that the other CNAs will watch to see how she applies the bed bolsters. When asked if she was aware of any risks associated with using bed bolsters, CNA #28 stated that a patient could try to get up over the bolsters. When asked if the bolsters were tight to the bed or if there was space between the bolsters and the bed, CNA #28 stated that the bolsters were tight to the bed. On 2/23/17 at 12:51 p.m., observation of CNA #28 applying the bed bolsters was conducted. Once the bolsters were secured onto the bed, a surveyor was able to stick an entire arm underneath the straps and

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pull up a few inches. CNA #28 stated, "I guess it's possible ...." CNA #28 confirmed the bolsters were on tight and the surveyor could put an entire arm through the straps.

On 2/23/17 at 2:34 p.m., an interview was conducted with RN #1 (the assistant director of nursing/quality assurance nurse). RN #1 stated review of residents' falls are completed by unit managers then discussed in the risk management meetings. RN #1 stated assessments of fall interventions are discussed in risk management meetings and then the unit managers are responsible for the oversight and management of the interventions. When asked if an assessment for the safety risks of fall interventions is completed, RN #1 stated, "I don't think that is part of the process." When asked if fall interventions are reassessed for each resident, RN #1 stated that should depend on if the resident has sustained another fall and if so, then a different intervention should be implemented. RN #1 was asked if an assessment for the safety risks of fall interventions is completed when fall interventions are reviewed; RN #1 stated this was not part of the process. When asked if the risk management team was responsible for ensuring policies and procedures for these matters were in place for nursing staff, RN #1 stated, "Yes." In regards to the purpose of the post fall observation forms that RN #1 had completed, RN #1 stated she completes the forms to see if the nursing staff followed up with prevention and to make sure an intervention was implemented. RN #1 stated she reviews the physician order for the intervention, asks the unit manager if the intervention has been put in place but does not

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F 323	Continued From page 169 look to see if the intervention is safe or in place. On 2/27/17 at 11:25 a.m., Resident #14 was observed in a wheelchair in the dining room. Observation of the resident's room failed to reveal bed bolsters. On 2/28/17 at 2:37 p.m., an interview was conducted with OSM (other staff member) #3 (the physical therapist). OSM #3 stated when he was working with Resident #14 the resident was able to walk at least 50 feet times three with a rolling walker and minimal assistant. OSM #3 stated the resident could also propel self in the wheelchair but had difficulties with forward leaning. When asked if he participated in any assessments or the application of Resident #14's bed bolsters, OSM #3 stated he wasn't aware the resident had bed bolsters. On 2/27/17 at 3:38 p.m., ASM (administrative staff member) #2 (the director of nursing) and the former director of nursing who was standing in for the administrator for the day were made aware of the above findings. No further information was presented prior to exit. (1) "Parkinson's disease (PD) is a type of movement disorder. It happens when nerve cells in the brain don't produce enough of a brain chemical called dopamine..." This information was obtained from the website: https://medlineplus.gov/parkinsonsdisease.html (2) "Dementia is the name for a group of symptoms caused by disorders that affect the brain. It is not a specific disease. People with	F 323		

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dementia may not be able to think well enough to do normal activities, such as getting dressed or eating. They may lose their ability to solve problems or control their emotions. Their personalities may change. They may become agitated or see things that are not there..." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=dementia&_ga=1.67884881.139120270.1477942321

(3) "Insomnia is a common sleep disorder. If you have it, you may have trouble falling asleep, staying asleep, or both..." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=insomnia

3. The facility staff failed to evaluate and assess for the appropriate and continued use of bolsters [1] (wedge shaped foam devices 34 inches long by 7 inches height by 8 inches depth placed on the edge and located mid mattress on both sides of the mattress and secured to the bedframe with straps that buckle) as assistive devices for the prevention of falls out of the bed. After placing the bolsters on Resident #3's bed for safety on 1/5/17, Resident #3 fell out of his bed on 2/11/17 while the bolsters were in place.

Resident #3 was admitted to the facility on 8/9/13 with a readmission on 4/20/15 with diagnoses that included, but were not limited to; left craniotomy (1) (the surgical removal of part of the bone from the skull to expose the brain), high blood pressure, aphasia (difficulty with talking), glaucoma (a disease of the eye causing

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blindness), heart disease, agitation, a traumatic brain injury, and difficulty swallowing.

Resident #3's most recent MDS (minimum data set) is a quarterly assessment with an ARD (assessment reference date) of 1/27/17. Resident #3 was coded as being unable to complete the Section C, Cognitive Patterns, BIMS (brief interview for mental status) and Resident #3 was coded by staff as being severely cognitively impaired. Resident #3 was coded as being totally dependent of two people with bed mobility.

A review of Resident #3's clinical record revealed documentation that he had fallen on six occasions since 4/1/2016 on the following dates; 4/21/16, 6/5/16, 7/27/16, 8/24/16, 1/4/17 and 2/11/17. The following falls were documented as being found on floor beside the bed; 6/5/16, 1/4/17 and 2/11/17. There is no documentation concerning the details of the falls that occurred on 4/21/16 and 7/27/16.

A review of Resident #3's clinical record revealed, in part, a physician order dated 1/5/17 that documented, in part, the following; "Received Date: 1/5/2017 Start Date: 1/5/2017 Order Description: BOLSTERS TO BED AT ALL TIMES." Signed by ASM (administrative staff member) #3, the medical doctor, on 1/5/17 at 4:32 P.M.

A review of Resident #3's TAR (treatment administration record) dated 2/1/2017 - 2-24/2017 revealed, in part, the following fall interventions in place prior to the new order for bolsters; "Fall alarm on at all times. Start / End Date 6/2/2014 - Open Ended. Floor mats to b/L (bilateral) bedside while in bed. Start / End Date 6/2/2014 - Open

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F 323	Continued From page 172 Ended. Low bed in lowest position while in bed. Start / End Date; 6/2/2014 - Open Ended." All interventions were checked off as completed (observed to be in place) each day from 2/1/2017 - 2/22/2017. A review of Resident #3's nursing progress notes revealed, in part, the following documentation; - "1/4/2017 8:40 PM writer called to room by staff, resident found in floor on knees on mat, bed in the lowest position, fall alarms in place and functioning, no injuries noted, MD (medical doctor) / RP (responsible party called and made aware." - "2/11/2017 2:14 AM Bed pad and fall alarm sounding, staff entered room, res (resident) noted on knees on fall mat. No injuries noted. Res assisted back to bed, but he continued to try to get of bed, res assisted up in w/c (wheel chair) and brought to dayroom." A review of Resident #3's incident reports did not reveal that an incident report was completed for the fall that occurred on 1/4/2017. An incident report dated 2/11/17 revealed, in part, the following documentation; "Brief Description; Bed pad and fall alarm sounding, staff entered room, re. noted on his knees on the fall mat. The following descriptors on the incident report were checked as "yes"; "Was bed/personal alarm in use? Were bed rails present? Position of bed rails? Up." A facility form "Post Fall Observation" dated 2/11/2017 documented, in part, the following; "Creator: (Name of RN [registered nurse] #1, the assistant director of nursing]) Date: 2/11/2017	F 323		

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F 323	Continued From page 173 4:29 PM. Completed Date: 2/15/2017 4:36 PM. Detailed description of the fall? bedpad and fall alarm sounding, staff entered room, resident noted on hia (sic) knees on the fall mat. What was the resident's location prior to the fall? (In bed checked). Restraints / Adaptive Equipment: fall alarm, floor mats, low bed, bed pad alarm, b/l (bilateral) bolsters to bed. Does resident receive any of the following types of medications? Antipsychotics/Neuroleptics checked. Fall history - How often has resident fallen in last 90 days? resident has fell (sic) once in the past 90 days. Is there a pattern to resident's falls? If so, describe. no. Evaluation: Summarize potential factors that could have contributed to the fall. (no response provided). Plan of Care: Describe measures to be taken to prevent further falls. (no response provided)." Continued review of Resident #3's clinical record revealed three fall risk assessments completed on 4/24/2016 with a score of 16; 7/29/2016 with a score of 15 and 1/21/2017 with a score of 16. The fall risk assessment provides, in part, the following documentation; "Fall Risk Score - Score of 10 or higher represents a high risk for falls." On the fall risk assessment dated 1/21/17 the following documentation is provided; "Plan of Care: Indicate Care Plan action taken. Continue Current Plan of Care." A review of the Unit Manager's Investigation Reports for Resident #3 did not reveal that an investigation had been completed for Resident #3's falls that had occurred on 4/21/16, 6/5/16, 7/27/16, 1/4/17 and 2/11/17. A review of Resident #3's clinical record failed to reveal any occupational or physical therapy notes.	F 323		

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F 323	Continued From page 174 A review of the "Rehabilitation Screening Form" provided by the rehabilitation therapy revealed that a "Resident Screen" had been performed by the therapy department on Resident #3 on 1/11/17. The following areas were assessed during the screening process; physical functions/ROM (range of motion), mobility, nutrition/swallowing, skin condition, and communication/cognition. The following, in part, was documented at the end of the form; "Results of Interdisciplinary Rehab (rehabilitation) Screen: No Change." Signed and dated by therapy on 1/11/17. A review of Resident #3's comprehensive care plan with an initial date of 8/9/2013 and a review date of 2/1/2017 revealed, in part, the following documentation; "Problem Start Date 2/1/2017. Category: Falls. FALL RISK = 16. EXT (extensive) TO TOTAL OF ONE OR TWO WITH ADLS (activities of daily living). EXTENSIVE ASSIST OF TWO AND HOYER LIFT (a brand of patient lifting device used to transfer people from one surface to another) FOR TRANSFERS, CONFUSION/ANXETY/AGITATION H/O (history of) FALLS. DX (diagnoses) OF OSTEOARTHRITIS WITH C/O (complaint of) PAIN AT TIMES AND POTENTIAL FOR INJURY. UNSTEADY BALANCE. HAS CHAIR PAD ALARM, FALL ALARM BED ALARM AND FLOOR MATS BESIDE BED FOR SAFETY. BOLSTERS TO BED. NO FALLS THIS REVIEW. Approach; FALL/CHAIR/BED PAD ALARMS ON AS ORDERED - MONITOR FOR PROPER PLACEMENT - MONITOR RESIDENT FOR TAKING FALL ALARMS OFF; DOCUMENT AND REPLACE AS NEEDED - ENSURE ALARMS ARE IN GOOD WORKING ORDER; CHANGE	F 323		

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BATTERIES ROUTINELY AND PRN (as needed); FLOOR MATS BESIDE BED; HAVE BED IN LOWEST STETTING WITH BREAKS ON. KEEP BED IN LOW POSITION WITH FALL MATS AS ORDERED. MONITOR AND REPORT FALLS AND INTERVENTIONS PUT INTO PLACE."

There were no further directives in the comprehensive care plan in regards to the bolsters in place on the bed.

On 2/22/17 at 11:30 a.m. this writer asked permission to enter into Resident #3's room, Resident #3 was not in the room but a lady was there putting away laundry, when asked her relationship to Resident #3 she stated she was his wife. This writer observed that Resident #3's bed was fully made with the side rails up bilaterally. On both sides of the bed against the side rails bolsters were attached to the bed and were observed to start at the point where the head would be positioned and extend 3/4 of the way down the bed. This writer asked Resident #3's wife (responsible party) what the bolsters were and why were they being used. Resident #3's wife stated that they were there to prevent him from falling out of the bed, Resident #3's wife further stated that he often attempted to climb out of the bed, that he had suffered a brain injury from an ATV (all-terrain vehicle) accident and he could no longer understand or remember directions to stay in the bed.

On 2/22/2017 at 2:45 p.m. an interview was conducted with LPN (licensed practical nurse) #5, a floor nurse. LPN #5 was asked who decides the interventions to be used when a resident fell. LPN #5 stated, "Whichever nurse is working with the resident when they fall decides on which

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F 323	Continued From page 176 intervention to put in place, after that we do a therapy referral, we always do that after a fall." LPN #5 was asked to give examples of the types of interventions that could be put in place, LPN #5 stated, "Fall alarms, seat pad alarms and if they try to climb out of the bed, then we use the bolsters." LPN #5 was asked who would review the interventions after they were put into place, LPN #5 stated, "They are reviewed at the risk management meeting." On 2/22/17 at 3:50 p.m. Resident #3 was observed self-propelling while seated in a wheelchair going into his room. Resident #3 was observed to have mobility of his arms. Resident #3's bed was observed at this time to have the bilateral bolsters in place on the bed. On 2/22/17 at 5:22 p.m., an interview was conducted with ASM #2 and LPN (licensed practical nurse) #6 (a MDS coordinator). ASM #2 stated residents' fall risk is assessed starting at admission then quarterly and yearly. ASM #2 stated if a resident is at risk for falls or has a history of falls then interventions are implemented and the interventions are determined based on the facility falls prevention policy and procedure. ASM #2 stated when a resident falls, the nurse reports the fall to the physician and responsible party, implements an intervention and completes an incident report within 24 hours. ASM #2 stated the physician follows up with the incident report and the unit manager assesses the intervention for appropriateness and turns the report in to her (ASM #2). ASM #2 stated the fall is then discussed at the weekly risk management meeting and the interdisciplinary team discusses each resident's fall, the intervention that was implemented and whether the team thinks the	F 323		

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intervention is a good idea or if the resident could benefit from a different intervention. When asked how the team decides if an intervention is appropriate, ASM #2 stated the decision is based on nursing judgement and individualized based on the resident. When asked if residents' interventions are routinely reassessed, ASM #2 stated residents who have fallen during the previous week are discussed at the risk management meeting and routine reassessments should be done quarterly at care plan meetings. ASM #2 and LPN #6 were asked to demonstrate how the process was completed as described for Resident #3. ASM #2 and LPN #6 were unable to provide any documentation from the paper clinical record or on the electronic medical record that supported their verbalization of the process. ASM #2 and LPN #6 were asked the purpose of the bed bolsters. ASM #2 stated the purpose was to establish perimeters to keep residents from falling out of bed. ASM #2 and LPN #6 were asked to provide the facility policy and procedure for operationalizing bolsters to include assessment and reassessments of the safety and appropriateness for the use of bolsters. ASM #2 and LPN #6 were unable to verbalize a process or provide a policy.

On 2/23/17 at 12:15 p.m., an interview was conducted with LPN #17. When asked the process if a resident has a fall, LPN #17 stated the nurse should go in and assess the resident for any injuries, complete a fall incident report, and notify the physician and family. LPN #17 stated she might also send a referral to therapy for evaluation. When asked what type of interventions she would put in place for fall prevention, LPN #17 stated, "It depends on how the resident fell. If the resident fell out of bed, I

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might write an order for side rails." When asked what LPN #17 could tell this writer about bolsters, LPN #17 stated bolsters keep the residents from falling out of the bed. LPN #17 stated staff would not order or place bolsters as a first intervention, but if a resident continued to fall out of bed, bolsters would be put into place. When asked how nursing would determine that bolsters were a safe and effective intervention for a resident, LPN #17 stated, "We would just put it on the bed. They are padded and cushioned." LPN #17 stated if the bolsters do not create a problem for the resident with positioning or if the resident does not attempt to crawl over the bolsters, then they should be a safe intervention to use. When asked if residents are assessed for safety prior to the bolsters being put into place, LPN #17 stated, "Yes." When asked how nursing assesses for the safe use of bolsters or where this assessment is documented, LPN #17 stated, "We would discuss with the unit manager and therapy. Most of the time we consult with therapy." LPN #17 was not sure if therapy assessed a resident for the use of bolsters. When asked the potential risks of using bolsters, LPN #17 stated that the resident could climb over them. When asked who applies the bolsters to the bed, LPN #17 stated that the nursing staff applied bolsters. When asked how to safely apply bed bolsters, LPN #17 stated, "It comes with straps that are Velcro and the straps go under the bed and come back over the bed. There are directions that show how to tighten." When asked if any monitoring was conducted after bed bolsters were put into place, LPN #17 stated, "We look at the bed every shift but we don't monitor every 30 minutes." When asked what nursing is looking for and checking off on the TAR (treatment administration record) for bed bolsters, LPN #17 stated, "We are signing that

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F 323	Continued From page 179 the bed bolsters are intact on the bed." On 2/23/17 at 12:30 p.m., an interview was conducted with RN (Registered Nurse) #7 regarding falls. RN #7 stated that falls were discussed in risk management meetings once a week. RN #7 stated that the nurse who was present during the fall would implement an intervention and then this would be discussed in the risk management meetings to determine if the intervention was appropriate. When asked at what point bolsters would be put into place, RN #7 stated that she could not give a generic answer because interventions that are put into place are different for each individual. RN #7 stated that bolsters would be put into place if the resident benefitted from them. When asked how nursing determined if bolsters were safe and appropriate for a resident, RN #7 stated, "I don't know. Based upon the resident's reactions because you don't know how a resident is going to respond to it. It's case by case." When asked what risks are associated with bolster use, RN #7 stated, "The resident could get caught up in it or crawl over them. I don't think it's a restraint of any kind." When asked what it meant on the TAR (treatment administration record) when nursing was signing off that bed bolsters were in place, RN #7 stated, "That is just an FYI (for your information) the resident uses bed bolsters." On 2/23/17 at 12:45 p.m., an interview was conducted with LPN #11. LPN #11 was asked when bolsters would be considered and stated she guessed when the resident repeatedly tried to climb out of bed and staff had tried, "everything else." When asked how she would determine if a bolster was safe and appropriate for each resident, LPN #11 stated she didn't apply bolsters	F 323		

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and had not received training on the application of, monitoring of and assessment of residents for the safe use of bolsters. LPN #11 stated bolsters weren't used much during the day and staff tried to keep residents who were at risk for falls up during the day. LPN #11 was asked what she would do if a resident she was caring for needed to have a bolster applied. LPN #11 stated she would tell CNA #28 during the week because she was responsible for application of the bolsters. When asked what she would do during the weekend, LPN #11 stated, "Usually the aides know how to. I would tell them it needs to be put in place." When asked who was responsible for assessing residents for safety of bolster use, LPN #11 stated the unit managers were responsible and bolsters were an intervention she was not comfortable with recommending because she was not familiar with them. LPN #11 was read the bolster order on Resident #3's TAR and asked what she was indicating by signing off the bolster order. LPN #11 stated she was signing off that the bolsters were on the bed and nothing else.

On 2/23/17 at 12:46 p.m., an interview was conducted with CNA #28 (the medical records employee). CNA #28 stated that she buys the bed bolsters for the facility and applies some of them to the beds. CNA #28 stated that the other CNAs will watch to see how she applies the bed bolsters. When asked how she applies the bed bolsters, CNA #28 stated that there are bolsters to each side of the bed with straps. The straps will go underneath the bed frame and hook back over the top where the straps clip together. CNA #28 stated that the bed bolsters come with a manual or directions on how to apply. When asked if she was aware of any risks associated

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F 323	Continued From page 181 with using bed bolsters, CNA #28 stated that a patient could try to get up over the bolsters. On 2/23/17 at 2:34 p.m. an interview was conducted with RN #1, the QA (quality assurance nurse). RN #1 was asked to describe her role in regards to a resident who falls. RN #1 stated that she would go over the incident report at the weekly risk management meeting and "come up" with an intervention based on the situation. RN #1 was asked how she would determine the safest / most appropriate intervention to use. RN #1 stated that she would start with fall alarms then go to a low bed with bilateral fall mats. When asked about the bolsters RN #1 stated, "We are not going to use bolsters at all now." RN #1 was asked whether prior to the removal of all the bolsters from the facility that morning was there a process in place that the nursing staff could refer to for guidance regarding which intervention should be chosen. RN #1 stated there was nothing. When asked if an assessment for the safety risks of fall interventions is completed, RN #1 stated, "I don't think that is part of the process." When asked if fall interventions are reassessed for each resident, RN #1 stated that should depend on if the resident has sustained another fall and if so, then a different intervention should be implemented. RN #1 was asked if an assessment for the safety risks of fall interventions is completed when fall interventions are reviewed; RN #1 stated this was not part of the process. When asked if the risk management team was responsible for ensuring policies and procedures for these matters were in place for nursing staff, RN #1 stated, "Yes." In regards to the purpose of the post fall observation forms that RN #1 had completed, RN #1 stated	F 323		

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she completes the forms to see if the nursing staff followed up with prevention and to make sure an intervention was implemented. RN #1 stated she reviews the physician order for the intervention, asks the unit manager if the intervention has been put in place but does not look to see if the intervention is safe or in place.

On 2/27/17 at 1:37 p.m., an interview was conducted with OSM #5 (the therapy/rehab program manager/physical therapist). OSM #5 was asked to describe the role the therapy department played in a resident's care after a fall. OSM #5 stated the therapy department is notified of each fall through a referral slip or via the risk management meetings. OSM #5 stated once the therapy department is notified that a resident has fallen, she has a therapist complete a screen to see if there is something the therapy department can work on (if the resident would benefit from therapy). OSM #5 stated if the screen determines the resident would not benefit from therapy then the next step is to "work on safety interventions with nursing like floor mats." OSM #5 stated she usually lets the nursing staff know the resident is not a candidate for rehab then the nursing staff decides on the interventions. OSM #5 stated sometimes the physical therapists may make suggestions but it is the responsibility of nursing staff to assess the intervention to see if it is safe for the resident. At this time, OSM #5 confirmed she didn't play any role in the assessment of the safety of bolsters for residents. OSM #5 stated sometimes the therapy department receives a referral to look at residents for positioning. OSM #5 stated in that case therapy staff would assess the appropriateness of the devices including bolsters if the resident had them. When asked how the therapy staff

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assesses bolsters to determine appropriateness, OSM #5 stated she wasn't sure if the therapy staff had ever assessed a resident for positioning related to bolsters but if they did, they would assess the resident for safety and make sure the bolsters were safe. When asked how that safety assessment would be conducted, OSM #5 stated that was hard for her to answer because the occupational therapist would be the person to complete the assessment. During this interview, OSM #5 was asked what she would recommend if a resident crawled over a bolster. OSM #5 stated she would recommend the removal of the bolsters. OSM #5 stated, "It's really not doing anything if they are climbing over and falling."

On 2/27/17 at 2:20 p.m., an interview was conducted with OSM #2 (an occupational therapist). OSM #2 was asked to describe the role he played in a resident's care after a fall. OSM #2 stated his department head attends meetings and once those meetings occur, the therapy staff is asked to complete screens. OSM #2 stated screens are also completed each quarter. When asked to describe a screen, OSM #2 stated a screen can be done by any one of the three therapy disciplines (physical therapy, occupational therapy or speech therapy) and is completed for all three disciplines. OSM #2 stated the screen consists of taking a look at the individual and getting an idea of what the individual's needs are and what the therapy department can provide. OSM #2 stated the screen consists of observation of the resident and asking the nursing department questions but does not include hands on physical interaction because at that point there is no physician's order for the therapists to treat the resident. OSM #2 stated the screen determines if there is nothing

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the therapy department can do for the resident or if the resident will benefit from therapy and if so, a physician's order to treat is obtained. OSM #2 was asked if he plays a role in the assessment of fall prevention devices. OSM #2 stated he notes the devices that are implemented when he completes a screen but he wasn't sure if the appropriateness of the device was discussed at that time. OSM #2 stated discussion of the appropriateness of fall prevention devices could verbally occur but not documented on a form. OSM #2 stated referral forms appear on his desk or the therapy director comes to him. When asked if he is verbally told the interventions in place for that resident and discusses the safety of those interventions, OSM #2 stated, "I don't think that comes up very much or at all." When asked the importance of an assessment of the relevance of interventions, OSM #2 stated this was importance and he notes the resident's behaviors, diagnoses, if the person is static (unable to move) or dynamic (able to move) because positioning is different for a static person as opposed to a dynamic person. When asked to provide an example of how this thought process occurs related to assessing the appropriateness of an intervention, OSM #2 stated for a static person, he looks at basic physics and some static people slide in their seat so strategies that increase friction such as a built up cushions are used. OSM #2 stated for residents who are dynamic, he assesses their safety awareness and posture in wheelchairs to see if they are aware and able to respond in order to correct their balance. OSM #2 was asked if this type of thought process occurred when nurses implemented interventions/devices. OSM #2 stated he didn't think that "fine tuning" occurred and he thought a lot of times nurses think, "That

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worked for Ms. X so it may work for Ms. Y." OSM #2 stated the therapy staff takes a look at the "whole picture." OSM #2 was asked the purpose of bolsters (termed bilateral bed wedges or bed ramps by OSM #2). OSM #2 stated the bolsters were used to assist with safety for people who can inadvertently roll out of bed. OSM #2 stated he looks at the ability of the resident and if the bolster is flush with the mattress. When asked if there were any risks for residents trying to get out of bed with bolsters in place, OSM #2 stated he didn't know if they were any more dangerous than a bedrail because it was an obstacle. OSM #2 stated staff must complete trial and error to see what works for residents. When asked if staff conducts conversations to discuss whether interventions such as fall mats and bolsters are safe for residents, OSM #2 stated the staff did not. OSM #2 was asked if there was a discussion held regarding the safe use of bolsters for Resident #3. OSM #2 stated he knew therapy staff had periodically looked at the resident and there was no variation in his condition. When asked if he had any discussions with other staff regarding the safe use of bolsters for Resident #3, OSM #2 stated he had not.

On 2/27/17 at 4:43 p.m., an interview was conducted with ASM #3 (Resident #7's physician). ASM #3 was asked to describe her role in the implementation of fall interventions. ASM #3 stated she usually receives a recommendation and she says yes it's a good idea or it's not a good idea. ASM #3 stated sometimes she asks the physical therapy department for recommendations regarding devices. ASM #3 was asked to describe her assessment as to whether bolsters are a good idea for residents. ASM #3 stated she is

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generally not the physician on call because she is the "house" physician. ASM #3 stated if staff asks to implement bolsters or if she has recommended bolsters then she has seen the resident to decide if that's a valid recommendation. ASM #3 stated she has usually seen good results with bolsters regarding residents who are bed bound and don't roll or turn. ASM #3 was asked if she attended the risk management meetings. ASM #3 stated she did every week. ASM #3 was asked if there were discussions about fall interventions and the validity of the interventions for each resident. ASM #3 stated, "Yes and if we need to change (the interventions) we talk about it." ASM #3 was asked if the risk management team discusses the safety and effectiveness of fall interventions. ASM #3 stated this was discussed only if there was an issue. When asked if a discussion should be held if a resident crawls over a bed bolster, ASM #3 stated, "We usually talk about that." ASM #3 was asked if she was aware Resident #3 continued with bolsters in place although the resident had crawled over the bolsters and fallen on 2/11/17. ASM #3 stated she didn't recall any information off the top of her head. When asked if the need for bolsters should have been reassessed after Resident #7 crawled over them, ASM #3 stated, "I would agree with that." When ASM #3 was asked if the reassessment of the bolsters should have been a function of the risk management team, ASM #3 stated, "Yeah."

On 2/27/17 at 5:50 p.m. an end of the day meeting was conducted with ASM #1, the administrator, ASM #2, the director of nursing, LPN #2, the north wing unit manager, OSM (other staff member) #4, the dietary manager, OSM #7,

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F 323	Continued From page 187 the business manager and OSM #1, the director of maintenance. The administrative staff was made aware of the concern and stated that there was no further information that they could provide. A review of the facility policy "Policy for Completion of Incident Report" revealed, in part, the following documentation; "When a resident fall (sic) his/her charge nurse fills out an incident report, then the charge nurse implements a (sic) intervention, writes order for the intervention, then the charge nurse ensures that the intervention was carried out. No further information was provided prior to the end of the survey process. (1) This information was obtained from the following website; http://www.hopkinsmedicine.org/healthlibrary/_procedures/neurological/craniotomy_92,p08767	F 323		
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments	F 328	1. Resident #4 has her oxygen regulator set on 2L/min as ordered by the M.D. The shift charge nurse will check at the beginning of the shift to assure the correct liter flow. 2. All Residents who have orders for oxygen have been checked by the unit managers to assure correct liter flow per physician's order. 3. All licensed nursing staff have been inserviced on checking liter flow when making shift rounds. The charge nurses must check liter flow prior to signing off on the treatment sheets. When the charge nurse signs the treatment sheet she is stating that she has checked and the liter flow is correct. The unit managers will monitor the charge nurse daily.	02/24/17 03/01/17 03/29/17

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F 328	Continued From page 188 (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to ... prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals	F 328	4. The Unit Managers will report to the risk management meeting weekly on the outcome of daily monitoring. The QA committee will monitor quarterly.	03/22/17

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F 328	Continued From page 189 and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to administer oxygen according to the physician's order for one of 26 residents in the survey sample, Resident #4. On 2/21/17 and 2/22/17, Resident #4 was observed to have oxygen flowing at the rate of 3 lpm (three liters per minute). The physician's order was for the oxygen to be administered at the rate of 2 lpm (two liters per minute). The findings include: Resident #4 was admitted to the facility on 6/13/13 and most recently readmitted on 5/2/16 with diagnoses including, but not limited to: heart disease, breast cancer, diabetes, and high blood pressure. On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 1/22/17, Resident #4 was coded as being severely cognitively impaired for making daily decisions. She was coded as having received oxygen during the look back period. On the following dates and times, Resident #4 was observed lying in her bed with oxygen flowing through a nasal cannula (1) at the rate of 3 lpm (three liters per minute): 2/21/17 at 4:35 p.m.; 2/22/17 at 7:45 am; 2/22/17 at 10:05 a.m.; and 2/22/17 at 3:55 p.m. A review of the physician's orders for Resident #4	F 328		

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revealed the following order written on 7/17/16 and electronically signed by the physician: "O2 (oxygen) continuously running 2L/min (two liters per minute) via (by way of) NC (nasal cannula) r/t (related to) SOB (shortness of breath) and comfort measures every shift."

A review of Resident #4's comprehensive care plan dated 1/24/17 revealed, in part, the following: "Resident continues to decline; resident appears to be at the end of life...Oxygen per order."

On 2/23/17 at 11:35 a.m., LPN (licensed practical nurse) #5 was interviewed. LPN #5 was asked about the process for following the physician's order for oxygen administration to a resident. LPN #5 stated: "You visualize it. I try to do it when I first see a resident." She stated if a resident is on continuous oxygen by way of an oxygen concentrator, she may not look as closely at it as she would look at a portable oxygen tank. LPN #5 stated: "No one is supposed to be fiddling with the concentrator." She stated most orders for oxygen are at two liters per minute. When asked how she would verify whether or not a rate on a concentrator is correct, LPN #5 stated: "There's an order. It's also on the TAR (treatment administration record) to be signed off."

On 2/23/17 at 4:40 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns.

A review of the facility policy entitled "Oxygen Therapy - Mask and Nasal Cannula" revealed, in part, the following: "Oxygen administration requires a physician's order...Turn on flowmeter

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F 328	Continued From page 191 to prescribed rate and check rate of flow." No further information was provided prior to exit. (1) "Oxygen therapy may help you function better and be more active. Oxygen is supplied in a metal cylinder or other container. It flows through a tube and is delivered to your lungs in one of the following ways...Through a nasal cannula, which consists of two small plastic tubes, or prongs, that are placed in both nostrils." This information is taken from the website http://www.nhlbi.nih.gov/health/health-topics/topics/oxt. According to Fundamentals of Nursing, Perry and Potter, 6th edition, page 1122, "Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity. As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration."	F 328		
F 329 SS=D	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or	F 329	t. Resident #9 and #11 will have nonpharmalogical interventions attempted with documentation in the progress note to support this prior to the administration of PRN medications. 2 A 100% audit of PRN medications and chart documentation for non-pharmacological interventions has been completed by the ADON and Unit Managers.	03/01/17 03/22/17

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F 329	Continued From page 192 (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to ensure a drug regimen must be free from unnecessary drugs for two of 26 residents in the survey sample, Resident # 9 and #11. 1. For Resident #9, facility staff failed to attempt non-pharmacological interventions prior to the administration of PRN (as needed) Xanax [1] 0.25 mg (milligrams) on 1/21/17. 2. On 1/20/17, the facility staff administered Haldol to Resident #11 without documenting the target behaviors and attempting non-pharmacological interventions prior to medication administration. The findings include: 1. Resident #9 was admitted to the facility on 9/21/15 with diagnoses that included but were not limited to major depressive disorder, systemic inflammation response syndrome, hypothyroidism, high blood pressure, high cholesterol, and chest pain. Resident #9's most	F 329	cont... 3. The licensed nursing staff has been instructed by the DON or designeeon the importance of non-pharmalogical interventions prior to the administration of PRN Medications. It was emphasised that documentation of these interventions must be in chart. 4. The Unit Manager wilt check PRN Medication daily and documentation. The Unit Manager will report PRN Medication usage to the Risk Managment committee weekly and the QA committee quarterly.	03/29/17 03/22/17

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F 329	Continued From page 193 recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/16/16. Resident #9 was coded as being cognitively intact in the ability to make daily decisions scoring 14 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #9 was coded as being independent with most ADLS (Activities of Daily Living) including transfers, ambulation, locomotion, eating, and hygiene; and limited assistance with bathing. Review of Resident #9's POS (Physician Order Sheet) dated 12/2016, documented the following order: "Xanax (alprazolam) -Schedule IV tablet; 0.25 mg (milligrams): ONE TAB (tablet); oral Special Instructions: PRN for Anxiety. Twice a day -PRN (as needed)." This order was imitated on 7/11/16. Review of Resident #9's January 2017 and February 2017 MAR (Medication Administration Record) revealed that Resident #9 received Xanax prn on 1/21/17 at 6:38 p.m. and 2/15/17 at 03:06p.m. The following was documented under "Reasons/Comments: 01/21/17 06:38 PM, PRN Reason: Behavior Issue. Comment: Anxiety. 02/15/17 03:06 PM, PRN Reason: Behavior Issue. Comment: Anxiety." Documentation of non-pharmacological interventions attempted prior to the administration of PRN Xanax could not be found in the clinical record. On 2/27/17 at 10:19 a.m., an interview was conducted with LPN (licensed practical nurse) #4. When asked about the process followed by staff, prior to administering a prn anti-anxiety agent,	F 329		

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LPN #4 stated that she would try any non-pharmacological interventions prior to the administration of medication. LPN #4 stated that she would attempt moving the resident to a quieter room, or redirection. When asked if non-pharmacological interventions should be documented in the clinical record, LPN #4 stated, "I hope I would. It should be in the nurse's notes." LPN #4 stated that the note would include all interventions that were done. LPN #4 confirmed that she could not find notes documenting non-pharmacological interventions attempted prior to the administration of Xanax on 1/21/17 and 2/15/17. LPN #4 stated that she was not the nurse who administered the Xanax on both days.

On 2/27/17 at 10:58 a.m., an interview was conducted with LPN #2, the unit manager. When asked about the process followed by staff, prior to administering a prn anti-anxiety medication, LPN #2 stated that she would generally try to calm the resident down by redirection, or other non-pharmacological interventions. LPN #2 stated that she would document interventions attempted in the nurses note and if the non-pharmacological interventions were not effective, she would then try medication.

On 2/27/17 at 4:43 p.m., an interview was conducted with LPN #5, the nurse who administered the Xanax on 1/21/17 and 2/15/17. LPN #5 stated that she attempts redirection with other activities if a resident is exhibiting a behavior prior to the administration of prn anti-anxiety medication. When asked if this would be documented anywhere, LPN #5 stated, "I try to in the nurse's notes, I don't always remember." When asked about the behaviors Resident #9 exhibits, LPN #5 stated that Resident

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F 329	Continued From page 195 #9 will get very anxious and agitated but it is rare. LPN #5 stated that she remembered she did attempt non-pharmacological interventions for Resident #9 on 2/15/17 by re-directing her and it was not effective. LPN #5 stated that she forgot to document that non-pharmacological interventions were attempted that day. LPN #5 stated that she did not remember trying non-pharmacological interventions on 1/21/17. On 2/27/17 at 5:50 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. The facility policy titled, "Protocol for Medication Administration" did not address non-pharmacological interventions prior to the administration of prn anti-anxiety medications. No further information was presented prior to exit. [1] Xanax- Used to relieve symptoms of anxiety and panic disorder in some patients. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008896/?report=details. 2. On 1/20/17, the facility staff administered Haldol to Resident #11 without documenting the target behaviors and attempting non-pharmacological interventions prior to medication administration. Resident #11 was admitted to the facility on 3/22/12 and most recently readmitted on 7/12/15	F 329		

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with diagnoses including, but not limited to dementia with behaviors, chronic kidney disease, high blood pressure, and depression. On the most recent MDS (minimum data set), an annual assessment with an assessment reference date of 1/6/17, Resident #11 was coded as being severely impaired for making daily decisions. He was coded as having demonstrated behaviors during four to six days of the look back period. He was coded as having received antipsychotic medications during each day of the look back period.

A review of Resident #11's clinical record revealed the following order dated 1/20/17 and signed by the physician on 1/20/17: "Haldol (haloperidol lactate) solution: 5 mg/ml (milligrams per milliliter); amt (amount): ONE MG injection."

A review of the MAR (medication administration record) revealed that the facility staff administered the medication to Resident #11 on 1/20/17 as ordered.

A review of the MAR notes and the nurses' notes for Resident #11 revealed no entries for 1/20/17.

A review of Resident #11's comprehensive care plan dated 1/12/17 and updated 1/19/17 revealed, in part, the following: "Do not argue with resident; attempt to resolve area of concern; if resident is abusive during care, ensure he is safe and come back later to finish; ensure safety of resident, staff, and other residents during combative behavior; remove resident out of the way of other residents...Meds (medications) per order; monitor and record effectiveness."

On 2/23/17 at 11:15 a.m., LPN (licensed practical

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F 329	Continued From page 197 nurse) #13 was interviewed. LPN # 13 was asked about the process followed by staff prior to administering an as-needed psychoactive medication to a resident. LPN #13 stated: "We would first try to do some form of redirection." She stated she would attempt one-on-one care, offer a snack, or offer some sort of activity to the resident in an attempt to redirect the resident and stop the negative behavior. When asked if an injection of Haldol is a preferred medication for behaviors, LPN #13 stated: "Not always, but sometimes." When asked what kind of documentation is required when staff administers as-needed injectable Haldol to a resident, LPN #13 stated: "You should document exactly what the resident is doing, why they need the Haldol. Then you should document what kinds of things you tried before you gave the medication. Then you should document how the resident reacts to the medication, if it helped or not." When shown the 1/20/17 order for Haldol, Resident #13's January MAR, and the nurses' notes for the dates surrounding 1/20/17, LPN #13 stated: "I guess I didn't do any of that. I'm not sure what was going on. I don't really remember. I can't say. I should have." On 2/23/17 at 4:40 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. A review of the facility policy entitled "Psychotropic Medication Protocol" revealed, in part, the following: "The Primary Care Physician determines the resident's need for the use of psychotropic medications. Nursing monitors the daily use noting any adverse effects such as increased somnolence or functional	F 329		

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F 329	Continued From page 198 decline...Nursing will monitor the presence of target behaviors on a daily basis charting by exception." A review of the facility policy entitled "Behavior Monitoring Program" revealed, in part, the following: "Physician or Clinician should identify the cause prior to using medication. Staff should consider the examples listed prior to initiation of drug therapy for behaviors. When medication is only option lowest dosage should be considered." A review of the facility policy entitled "Administration of Medications" revealed, in part, the following: "PRN (as needed) medication is charted with initials, and time is given in the corner of the box. The following situations require an accompanying note: behavior requiring use of PRN psychotropic." No further information was provided prior to exit. (1) "Haloperidol is used to treat psychotic disorders (conditions that cause difficulty telling the difference between things or ideas that are real and things or ideas that are not real). Haloperidol is also used to control motor tics (uncontrollable need to repeat certain body movements) and verbal tics (uncontrollable need to repeat sounds or words) in adults and children who have Tourette's disorder (condition characterized by motor or verbal tics). Haloperidol is also used to treat severe behavioral problems such as explosive, aggressive behavior or hyperactivity in children who cannot be treated with psychotherapy or with other medications. Haloperidol is in a group of medications called conventional antipsychotics. It works by decreasing abnormal excitement in the	F 329		

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F 329	Continued From page 199 brain...IMPORTANT WARNING: Studies have shown that older adults with dementia (a brain disorder that affects the ability to remember, think clearly, communicate, and perform daily activities and that may cause changes in mood and personality) who take antipsychotics (medications for mental illness) such as haloperidol have an increased chance of death during treatment. Haloperidol is not approved by the Food and Drug Administration (FDA) for the treatment of behavior problems in older adults with dementia." This information is taken from the website https://medlineplus.gov/druginfo/meds/a682180.html.	F 329		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of	F 371	1. Pan rack has been implemented to allow pans to air dry before storage. 2. A sanitation audit was completed by Registered Dietitian to include all indentified areas. 3. Dietary Manager reeducated all dietary staff on 2-21-17 and 2-22-17, content included proper drying and storage of pans. 4. Dietary Manager or designee will monitor and document on daily checklist. Sanitation audits will be completed quarterly and reviewed by Quality Assurance Committee.	02/21/17 02/21/17 02/21/17 02/22/17 02/22/17

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F 371	Continued From page 200 foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to wash and store cookware in a sanitary manner. The facility staff failed to allow cookware to air dry, and stacked the wet cookware one on top of the other. On observation, the cookware had water droplets on all sides. The findings include: On 2/21/17 at 1:25 p.m., observation was made of the kitchen. The surveyor was accompanied on the observation by OSM (other staff member) #4, the dietary manager. The surveyor observed three of five full size steam table pans, stacked one on top of the other. The pans were observed with water droplets on both the outside and inside. The surveyor observed six of seven half-size steam table pans, stacked one on top of the other. The pans were observed with water droplets on both the outside and inside. The surveyor observed five of ten full size sheet pans, stacked one on top of the other. The pans were observed with water droplets on both the outside and the inside. On 2/21/17 at 1:25 p.m., OSM #4 was asked about the stacked when wet pans. OSM #4 stated they were ready for use. She stated there should not have been any water on any of the pans. OSM #4 stated the presence of the water indicated that the pans had not been allowed to	F 371		

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F 371	Continued From page 201 fully air dry before being stored. She stated the water could be a place for bacteria to grow. A review of the facility policy entitled "Cleaning Dishes - Manual Dishwashing" revealed, in part, the following: "Allow dishes to air dry. Invert dishes in a single layer to air dry. Check all dishes to be sure they are clean and dry prior to storing." No further information was provided prior to exit. On 2/23/17 at 4:40 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns.	F 371		
F 497 SS=E	483.35(d)(7) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE (d)(7) Regular In-Service Education The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to ensure that 29 out of 51 facility CNA's (Certified Nursing Assistant) on payroll received the required minimum 12 hours per year (from anniversary to anniversary) of continuing education; CNA #1 through #17; and CNA #19 through #30.	F 497	1. The ADON is working to complete the 12 hours of inservice training for the C.N.A's cited in the 2567. Lecture and online education is being used. 2. A 100% review of all currently employed C.N.A's with their inservice records has been completed. 3. The ADON, who is in charge of the C.N.A inservices, has been instructed in the guideline for C.N.A. education. There are mandatory inservices as well as inservices based on the C.N.A performance reviews. The timeframe is from hire date to 12 month review date. The C.N.A inservice schedule will be set up on a monthly basis with all C.N.A's listed by Hire date and required inservices. 4. The DON will monitor the inservice schedule monthly and report to the QA Committee quarterly	03/22/17 03/30/17 03/22/17 03/30/17

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F 497	Continued From page 202 The findings include: On 2/28/17, a review of the CNA's continuing education logs for 2015 and 2016 was conducted. The review of the logs revealed the following: CNA #1 was hired on 9/25/14. From 9/25/15 to 9/25/16, CNA #1 had 7 hours and 30 minutes of continuing education; and 30 minutes thus far during the current year from 9/25/16 to 2/28/17 (day of survey). CNA #2 was hired on 6/21/12. From 6/21/15 to 6/21/16, CNA #2 had 5 of continuing education; and 5 hours and 10 minutes thus far during the current year from 6/21/16 to 2/28/17 (day of survey). CNA #3 was hired on 9/30/91. From 9/30/15 to 9/30/16, CNA #3 had 8 hours and 40 minutes of continuing education; and 1 hour and 15 minutes thus far during the current year from 9/30/16 to 2/28/17 (day of survey). CNA #4 was hired on 12/15/11. From 12/15/15 to 12/15/16, CNA #4 had only 50 minutes of continuing education; and none thus far during the current year from 12/15/16 to 2/28/17 (day of survey). CNA #5 was hired on 10/16/07. From 10/16/15 to 10/16/16, CNA #5 had 6 hours of continuing education; and none thus far during the current year from 10/16/16 to 2/28/17 (day of survey). CNA #6 was hired on 4/2/15. From 4/2/15 to 4/2/16, CNA #6 had 9 hours and 10 minutes of continuing education; and 1 hour thus far during	F 497		

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the current year from 4/2/16 to 2/28/17 (day of survey).

CNA #7 was hired on 5/25/05. From 5/25/15 to 5/25/16, CNA #7 had 3 hours of continuing education; and 3 hours and 25 minutes thus far during the current year from 5/25/16 to 2/28/17 (day of survey).

CNA #8 was hired on 6/6/04. From 6/6/15 to 6/6/16, CNA #8 had 9 hours and 50 minutes of continuing education; and 30 minutes thus far during the current year from 6/6/16 to 2/28/17 (day of survey).

CNA #9 was hired on 7/21/15. From 7/21/15 to 7/21/16, CNA #9 had 10 hours and 15 minutes of continuing education; and none thus far during the current year from 7/21/16 to 2/28/17 (day of survey).

CNA #10 was hired on 10/3/13. From 10/3/15 to 10/3/16, CNA #10 had 4 hours and 40 minutes of continuing education; and 1 hour and 15 minutes thus far during the current year from 10/3/16 to 2/28/17 (day of survey).

CNA #11 was hired on 4/30/14. From 4/30/15 to 4/30/16, CNA #11 had 4 hours and 40 minutes of continuing education; and 11 hours and 35 minutes thus far during the current year from 4/30/16 to 2/28/17 (day of survey).

CNA #12 was hired on 2/26/13. From 2/26/15 to 2/26/16, CNA #12 had 6 hours of continuing education; and 8 hour and 15 minutes during the current year from 2/26/16/16 to 2/28/17 (day of survey) (For CNA #12, the survey date was after the current anniversary date, indicating 2 full

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F 497	Continued From page 204 years of less than 12 hours per year of continuing education.) CNA #13 was hired on 5/14/09. From 5/14/15 to 5/14/16, CNA #13 had 3 hours of continuing education; and 4 hours thus far during the current year from 5/14/16 to 2/28/17 (day of survey). CNA #14 was hired on 10/17/14. From 10/17/15 to 10/17/16, CNA #14 had 5 hours and 5 minutes of continuing education; and none thus far during the current year from 10/17/16 to 2/28/17 (day of survey). CNA #15 was hired on 2/25/16. From 2/25/16 to 2/28/17 (day of survey, reflecting 1 complete year of employment during the survey) CNA #15 had 10 hours of continuing education. CNA #16 was hired on 1/31/09. From 1/31/15 to 1/31/16, CNA #16 had no hours of continuing education; and 2 hours and 35 minutes during the current year from 1/31/16 to 2/28/17 (day of survey). (For CNA #16, the survey date was after the current anniversary date, indicating 2 full years of less than 12 hours per year of continuing education.) CNA #17 was hired on 12/27/02. From 12/27/15 to 12/27/16, CNA #17 had 4 hours and 35 minutes of continuing education; and none thus far during the current year from 12/27/16 to 2/28/17 (day of survey). CNA #19 was hired on 7/24/08. From 7/24/15 to 7/24/16, CNA #19 had 4 hours and 50 minutes of continuing education; and 2 hours and 40 minutes thus far during the current year from 7/24/16 to 2/28/17 (day of survey).	F 497		

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F 497	Continued From page 205 CNA #20 was hired on 1/20/03. From 1/20/15 to 1/20/16, CNA #20 had 2 hours and 30 minutes of continuing education; and 6 hours during the current year from 1/20/16 to 2/28/17 (day of survey). (For CNA #20, the survey date was after the current anniversary date, indicating 2 full years of less than 12 hours per year of continuing education.) CNA #21 was hired on 9/15/11. From 9/15/15 to 9/15/16, CNA #21 had 7 hours and 30 minutes of continuing education; and none thus far during the current year from 9/15/16 to 2/28/17 (day of survey). CNA #22 was hired on 1/25/08. From 1/25/15 to 1/25/16, CNA #22 had 7 hours continuing education; for the anniversary year of 1/25/16 to 1/25/17, CNA #22 met the required 12 hours of continuing education for the anniversary year. CNA #23 was hired on 1/3/05. From 1/3/15 to 1/3/16, CNA #23 had 2 hours and 40 minutes of continuing education; and 10 hours and 55 minutes during the current anniversary year from 1/3/16 to 1/3/17. (For CNA #23, the survey date 2/28/17 was after the current anniversary date, indicating 2 full years of less than 12 hours per year of continuing education.) CNA #24 was hired on 12/2/90. From 12/2/14 to 12/2/15, CNA #24 had 2 hours of continuing education; and 2 hours and 5 minutes thus far during the current year from 12/2/15 to 12/2/16. (For CNA #24, the survey date was after the current anniversary date, indicating 2 full years of less than 12 hours per year of continuing education.)	F 497		

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F 497	Continued From page 206 CNA #25 was hired on 3/7/12. From 3/7/15 to 3/7/16, CNA #25 had 2 hours and 20 minutes of continuing education; and 2 hours and 5 minutes thus far during the current year from 3/7/16 to 2/28/17 (day of survey). CNA #26 was hired on 7/31/14. From 7/31/15 to 7/31/16, CNA #26 had 7 hours and 20 minutes of continuing education; and 2 hours thus far during the current year from 7/31/16 to 2/28/17 (day of survey). CNA #27 was hired on 12/12/12. From 12/12/15 to 12/12/16, CNA #27 had 8 hours and 10 minutes of continuing education; and 1 hour thus far during the current year from 12/12/16 to 2/28/17 (day of survey). CNA #28 was hired on 6/20/11. From 6/20/15 to 6/20/16, CNA #28 had 1 hour and 25 minutes of continuing education; and none thus far during the current year from 6/20/16 to 2/28/17 (day of survey). CNA #29 was hired on 11/12/09. From 11/12/15 to 11/12/16, CNA #29 had 4 hours and 15 minutes of continuing education; and 40 minutes thus far during the current year from 11/12/16 to 2/28/17 (day of survey). CNA #30 was hired on 7/16/15. From 7/16/15 to 7/16/16, CNA #30 had met the required hours of continuing education; and 45 minutes thus far during the current year from 7/16/16 to 2/28/17 (day of survey). On 2/28/17 at 2:30 p.m., an interview was conducted with RN #1 (Registered Nurse #1, the	F 497		

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F 497	Continued From page 207 Assistant Director of Nursing / Educator). She stated she had been in the position of staff education since about October of 2016 and was provided a list of 12 items that needed to be completed each year, but was never told that there was a minimum number of hours that had to be completed by each CNA each anniversary year. When asked if she had a policy on the required continuing education, she stated she did not have one. On 2/28/17 at 2:48 p.m., the Director of Nursing was made aware of the findings. No further information was provided by the end of the survey.	F 497		
F 502 SS=D	483.50(a)(1) ADMINISTRATION (a) Laboratory Services (1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, it was determined that facility staff failed to obtain a physician ordered laboratory test for one of 26 residents in the survey sample, Resident #6. For Resident #6, facility staff failed to obtain a physician ordered Albumin [1] level that was ordered on 9/28/16. The findings include: Resident #6 was admitted to the facility on	F 502	1. Resident #6 has had the albumin level drawn. The physician was made aware of the failure to draw this lab on 09/28/16 as ordered. New orders were written. 2. A 100% audit of all lab orders with results has been completed by the Unit Managers 3. A daily review by the Unit Managers of physicians orders to ensure lab orders have been documented in the appropriate areas to be drawn as ordered 4. The Unit Managers will report to the Risk Management the labs that were ordered and the results on a weekly basis. The DON will report to the QA committee quarterly.	10/18/16 03/22/17 03/22/17 03/22/17

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6/28/13 and readmitted on 1/5/17 with diagnoses that included but were not limited to high cholesterol, CVA (stroke), seizure disorder, aphasia [2], Multiple Sclerosis [3] and altered mental status. Resident #6's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/8/16. Resident #6 was coded as being cognitively impaired in the ability to make daily decisions scoring 04 out of 15 on the BIMS (Brief interview for mental status) exam. Resident #6 was coded as requiring extensive assistance with transfers, dressing, and eating, and total dependence on staff with bathing.

Review of Resident #6's clinical record revealed the following physician telephone order: "Received Date: 9/23/16, Start Date: 9/28/16 Order Description: Other Test: (Albumin), Frequency Once-One Time. Special Instructions: Per dietary recommendation." This order was created and verified by RN (Registered Nurse) #7.

Review of Resident #6's clinical record failed to reveal that the Albumin level was obtained.

Review of Resident #6's Nutrition care plan dated 9/20/16 and updated 11/30/16, documented the following intervention: "Approach start date: 9/20/16 MEDS (medications)/LABS (laboratory tests)/WEIGHT PER ORDER."

On 2/23/17 at 3:09 p.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). ASM #2 stated, "I couldn't find that lab that was requested on 9/28. It wasn't done." When asked why the laboratory test was not completed, ASM

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F 502	Continued From page 209 #2 stated, "I don't know, I was off that day." On 2/27/17 at 10:19 a.m., an interview was conducted with LPN #4. When asked about the process of obtaining a laboratory test, LPN #4 stated that orders for laboratory tests get put into the computer system and the UM (unit manager) usually draws the labs on certain lab days or for STAT (immediate labs). LPN #4 stated that once the laboratory test is obtained, it is placed in a box for an outside laboratory company to pick up and process. LPN #4 stated that the results are faxed to the facility and the physician is made aware of the results by nursing staff. On 12/27/17 at 12:05 p.m., an interview was conducted with RN (registered nurse) #7. RN #7 was asked about the process of obtaining a physician ordered laboratory test. RN #7 stated that when a physician orders a lab for a resident, the lab will be put onto a list and the list will get transcribed onto the laboratory calendar for resident's labs to be drawn on that particular day. RN #7 stated that Resident #6's lab (Albumin level ordered on 9/28/16) was an oversight on her part. RN#7 stated that Resident #6 did not make it to the calendar. On 2/23/17 at 3:09 p.m., ASM (administrative staff member) #2, the DON (Director of Nursing) was made aware of the above concerns. The facility policy titled, "Laboratory Order Sheet" documents the following: "All laboratory work is ordered on a standardized laboratory order sheet to minimize errors and omissions...Procedure: 1. On notification of necessary blood work the nurse completes a laboratory order sheet. 2. Nurse completes the necessary information on the	F 502		

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F 502	Continued From page 210 laboratory order sheet. 3. Nurse checks the appropriate space in front of the correct test. If the ordered laboratory work is not listed on the laboratory order sheet the test (s) is written in the "other" space. Indicate source of specimen. 4. The completed original laboratory order sheet is placed in the area designated at each nursing station." No further information was presented prior to exit. [Albumin]-Is the main protein in blood plasma. Low levels occur in conditions associated with malnutrition, inflammation, liver and kidney diseases. This information was obtained from the National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0023211/. [Aphasia]-Aphasia is a disorder caused by damage to the parts of the brain that control language. It can make it hard for you to read, write, and say what you mean to say. It is most common in adults who have had a stroke. Brain tumors, infections, injuries, and dementia can also cause it. This information was obtained from the National Institutes of Health. https://medlineplus.gov/aphasia.html. [Multiple Sclerosis]- Multiple sclerosis (MS) is a nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS. This information was obtained from The National Institutes of Health. https://medlineplus.gov/multiplesclerosis.html.	F 502		

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F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was	F 514	1. The nursing staff has been made aware of Residents #3, #7, and #9 not having documented non-pharmalogical interventions prior to administering Ativan and Haldol, Xanax. All Medication nurses are to document non-pharmalogical interventions prior to PRN medication adminstration 2. A 100% audit of PRN medications and chart documentation for non-pharamlogical interventions has been completed by the ADON and Unit Managers The Medical records employee will audit charts for improperly filed information. 3. All licensed staff has been educated on the use of non-pharmalogical interventions and documentation prior to administering PRN Medications. by DON or designee. The Medical Records employee has been instructed on the importance of correct filing of medical records. by DON or designee 4. PRN Mediciation usage and documentation will be reviewed weekly in Risk Management meeting and quarterly in the QA committee metting.	03/1/17 03/22/17 03/29/17 03/22/17

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determined that facility staff failed to maintain a complete and accurate clinical record for three of 26 residents in the survey sample, Resident #9, #3, #7.

1. a. For Resident #9, facility staff failed to document non-pharmacological interventions prior to the administration of PRN (as needed) Xanax [1] 0.25 mg (milligrams) on 2/15/17.

b. The facility staff filed a narcotic log belonging to another resident into Resident #9's clinical record.

2. The facility staff failed to document non-pharmacological interventions that were attempted prior to administering Ativan [1] (an anti-anxiolytic) on seven occasions in February 2017 and Haldol [2] (an hypnotic medication) on one occasion 12/2/16 to Resident #3.

3. The facility staff failed to document non-pharmacological interventions that were attempted with Resident #7 prior to the administration of the antipsychotic medication Haldol on 1/25/17.

The findings include:

1. a. Resident #9 was admitted to the facility on 9/21/15 with diagnoses that included but were not limited to major depressive disorder, systemic inflammation response syndrome, hypothyroidism, high blood pressure, high cholesterol, and chest pain. Resident #9's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/16/16. Resident #9 was coded as being cognitvely intact in the ability to make daily

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decisions scoring 14 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #9 was coded as being independent with most ADLS (Activities of Daily Living) including transfers, ambulation, locomotion, eating, and hygiene; and limited assistance with bathing.

Review of Resident #9's POS (Physician Order Sheet) dated 12/2016, documented the following order: "Xanax (alprazolam) -Schedule IV tablet; 0.25 mg (milligrams): ONE TAB (tablet); oral Special Instructions: PRN (as needed) for Anxiety. Twice a day -PRN." This order was initiated on 7/11/16.

Review of Resident #9's January 2017 and February 2017 MAR (Medication Administration Record) revealed that Resident #9 received Xanax prn on 1/21/17 at 6:38 p.m. and 2/15/17 at 3:06 p.m. The following was documented under "Reasons/Comments:
01/21/17 06:38 PM, PRN Reason: Behavior Issue. Comment: Anxiety.
02/15/17 03:06 PM, PRN Reason: Behavior Issue. Comment: Anxiety."

Documentation of non-pharmacological interventions attempted prior to the administration of PRN Xanax could not be found in the clinical record.

On 2/27/17 at 10:19 a.m., an interview was conducted with LPN (licensed practical nurse) #4. When asked about the process followed by staff, prior to administering a prn anti-anxiety agent, LPN #4 stated that she would try any non-pharmacological interventions prior to the administration of medication. LPN #4 stated that she would attempt moving the resident to a

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quieter room, or redirection. When asked if non-pharmacological interventions should be documented in the clinical record, LPN #4 stated, "I hope I would. It should be in the nurse's notes." LPN #4 stated that the note would include all interventions that were done. LPN #4 confirmed that she could not find notes documenting non-pharmacological interventions attempted prior to the administration of Xanax on 1/21/17 and 2/15/17. LPN #4 stated that she was not the nurse who administered the Xanax on both days.

On 2/27/17 at 10:58 a.m., an interview was conducted with LPN #2, the unit manager. When asked about the process followed by staff, prior to administering a prn anti-anxiety medication, LPN #2 stated that she would generally try to calm the resident down by redirection, or other non-pharmacological interventions. LPN #2 stated that she would document interventions attempted in the nurses note and if the non-pharmacological interventions were not effective, she would then try medication.

On 2/27/17 at 4:43 p.m., an interview was conducted with LPN #5, the nurse who administered the Xanax on 1/21/17 and 2/15/17. LPN #5 stated that she attempts redirection with other activities if a resident is exhibiting a behavior prior to the administration of prn anti-anxiety medication. When asked if this would be documented anywhere, LPN #5 stated, "I try to in the nurse's notes, I don't always remember." When asked about the behaviors Resident #9 exhibits, LPN #5 stated that Resident #9 will get very anxious and agitated but it is rare. LPN #5 stated that she remembered she did attempt non-pharmacological interventions for Resident #9 on 2/15/17 by re-directing her and it

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was not effective. LPN #5 stated that she forgot to document that non-pharmacological interventions were attempted that day. LPN #5 stated that she did not remember trying non-pharmacological interventions on 1/21/17.

On 2/27/17 at 5:50 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

No policy could be provided regarding maintaining a complete and accurate clinical record. No further information was presented prior to exit.

The following quotation is found in Potter and Perry's Fundamentals of Nursing 6th edition (2005, p.477): "Documentation is anything written or printed that is relied on as record or proof for authorized persons.
Documentation within a client medical record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive, and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice. Information in the client record provides a detailed account of the level of quality of care delivered to the clients."

[1] Xanax- Used to relieve symptoms of anxiety and panic disorder in some patients. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008896/?report=details.

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b. The facility staff filed a narcotic log belonging to another resident into Resident #9's clinical record.

Review of Resident #9's clinical record revealed a completed narcotic log for Oxycodone HCL [1] that belonged to a different resident.

On 12/27/17 at 12:05 p.m., an interview was conducted with RN (Registered Nurse) #7. When asked who was responsible for filing narcotic logs, RN #7 stated that medical records (CNA #28) would collect all completed logs and file them into the clinical record. RN #7 stated that it was never ok to have information on a resident in a different resident's clinical record.

CNA #28 could not be reached for an interview due to an emergency situation.

On 12/27/17 at 5:50 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit.

[1] Oxycodone- Narcotic analgesic used to relieve moderate to severe pain. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0001326/.

2. The facility staff failed to document non-pharmacological interventions that were attempted prior to administering Ativan [1] (an anti-anxiolytic) on seven occasions in February

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F 514	Continued From page 217 2017 and Haldol [2] (an hypnotic medication) on one occasion 12/2/16 to Resident #3. Resident #3 was admitted to the facility on 8/9/13 with a readmission on 4/20/15 with diagnoses that included, but were not limited to; left craniotomy [4] (the surgical removal of part of the bone from the skull to expose the brain), high blood pressure, aphasia (difficulty with talking), glaucoma (a disease of the eye causing blindness), heart disease, agitation, a traumatic brain injury, and difficulty swallowing. Resident #3's most recent MDS (minimum data set) is a quarterly assessment with an ARD (assessment reference date) of 1/27/17. Resident #3 was coded as being unable to complete the Section C, Cognitive Patterns, BIMS (brief interview for mental status) and Resident #3 was coded by staff as being severely cognitively impaired. Resident #3 was coded as having behavioral symptoms including "physical behavioral symptoms directed toward others" and "verbal behavioral symptoms directed toward others." These behaviors were coded as occurring one to three days during the 14 day lookback period. A review of Resident #3's clinical record revealed the following physician orders; "Prescription: Haldol (haloperidol lactate) solution: 5 mg/ (milligrams) / ml (milliliters); 1(one) mg; injection. Special Instructions; One time dose. Once-one time 05:30PM. Start Date 12/28/2016. End Date 12/28/2016. Signed Electronically." ""Ativan (Lorazepam - Schedule IV (four) tablet; 0.5 mg; Amount to Administer: ONE TAB. Twice A Day - PRN (as needed). PRN for	F 514		

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combativeness. Start /End Date: 9/29/20214 - Open Ended."

A review of Resident #3's clinical record did not reveal any documentation regarding non-pharmacological interventions prior to administering Ativan and Haldol on the following dates:
"Haldol administered on 12/2/16 at 6:39 PM
"Ativan administered on 2/3/17 at 1:43 PM; 2/4/17 at 2:53 AM and 4:07 PM; 2/5/17 at 4:22 PM; 2/12/17 at 1:50 AM; 2/16/17 at 7:05 AM; 2/21/17 at 7:47 AM"

A review of Resident #3's comprehensive care plan dated 8/9/2013 (date of admission) and a review / revise date of 2/1/2017 revealed, in part, the following documentation; "Problem: Problem Start Date: 2/1/2017. Category: Behavioral Symptoms; Head injury from ATV (all-terrain vehicle) accident in 2013. Can get agitated and physically abusive during care. Very confused. Potential for injury to self and staff daring combative episodes. Receives psychotropic [3] (a class of medication that alters chemical levels in the brain impacting mood and behavior) med (medication) daily and receives anxiety med PRN. 1:1 (one to one) effective at times but not always. Wife is very supportive. Has had increased episodes of combativeness with staff; has had another episode of hurting a staff member. Approach; Divert Resident's behavior by encouraging activity attendance. MD (medical doctor) and Pharm (pharmacy) to review drug regimen routinely and PRN; Monitor for drugs effectiveness; monitor for side effects from medication. Place resident when behavior is appropriate; Provide 1:1 sessions with resident; Seat resident where constant / near constant

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F 514	Continued From page 219 observation is possible. When resident becomes socially inappropriate / disruptive, provide comfort measures for basic needs (e.g., pain, hunger, toileting, too hot / cold, etc.)." On 2/22/17 at 1:50 p.m. an interview was conducted with LPN (licensed practical nurse) #2, the unit manager. LPN #2 was asked to describe the process for administering a prn medication when a resident was demonstrating behaviors/ combativeness during ADL care. LPN #2 stated that she would try non-pharmacological approaches and if they did not work she would administer prn medications as ordered. LPN #2 was asked whether or not the non-pharmacological approaches were documented anywhere. LPN #2 stated that they would document the administration of the medication in the MAR (medication admission record) and any non-pharmacological interventions would be documented in the nursing progress notes. On 2/27/17 at 10:10 a.m. an interview was conducted with LPN #4. LPN #4 was asked to describe the process followed prior to administering a prn antianxiety medication. LPN #4 stated, "If the resident is having anxiety, we move them from the situation and provide 1:1 and try other interventions, based on the resident, before giving a prn medication." LPN #4 was asked if the interventions attempted would be documented in the nursing progress notes. LPN #4 stated that she would. LPN #4 reviewed the dates that Resident #3 was administered Ativan and Haldol and was asked if interventions were documented for Resident #3. LPN #4 stated that she did not see any.	F 514		

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F 514	Continued From page 220 On 2/27/16 at 10::55 a.m. an interview was conducted with LPN #2, the unit manager. LPN #2 was asked where the documentation would be found indicating the non-pharmacological interventions attempted prior to administering Ativan and Haldol to Resident #3. LPN #2 stated, "It should be documented in the progress notes, what they tried to do." LPN #2 reviewed Resident #3's behavior monitoring documentation for the dates provided. LPN #2 stated, "We should have documented the interventions." On 2/27/17 at 1:35 p.m. an interview was conducted with LPN #8. LPN #8 was asked about Resident #3's behaviors. LPN #8 stated that he (Resident #3) could become combative and agitated. LPN #8 was asked what she did when the resident became combative/agitated. LPN #8 stated, "I provide non-pharmacological interventions prior to administering a medication. I provide one to one, he (Resident #3) likes coloring books and to watch television. I always try those distractions before going to the medication." LPN #8 reviewed the MAR and the progress notes for the dates above. LPN #8 stated, "It's just not documented, I should have done it." LPN #8 further stated, "Documentation for non-pharmacological interventions is not consistently evident for February." On 2/27/17 at 5:50 p.m. an end of the day meeting was conducted with ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, LPN #2, the north wing unit manager, OSM (other staff member) #4, the dietary manager, OSM #7, the business manager and OSM #1, the director of maintenance. The administrative staff was made aware of the concern. A policy was requested at this time that	F 514		

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F 514	Continued From page 221 described the process for behavior monitoring. A review of the facility document titled "Behavior Monitoring Program" revealed, in part, the following documentation; "Procedures: 1. Identification of problem behavior 2. Resident assessment 3. Specific systematic behavior interventions 4. Documentation of effectiveness of intervention 5. Adjustments based on observed results. Documentation should include features, frequency and duration of behavior as well as consequences of behavior for the resident as well as other residents. The prescribed intervention must be communicated in medical record and to all appropriate staff members e.g. redirect resident when he claims that he must go home or repetitious trips to bathroom. Staff must document the efficacy of that behavioral intervention." No further information was provided prior to the end of the survey process. [1] Haloperidol (Haldol) is used to treat psychotic disorders (conditions that cause difficulty telling the difference between things or ideas that are real and things or ideas that are not real). This information was obtained from the following website; https://medlineplus.gov/druginfo/meds/a682180.html [2] Lorazepam (Ativan) is used to relieve anxiety. This information was obtained from the following website; https://medlineplus.gov/druginfo/meds/a682053.html	F 514		

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F 514	Continued From page 222 [3] This information was obtained from the following website; https://www.nimh.nih.gov/health/topics/mental-health-medications/index.shtml [4] This information was obtained from the following website; http://www.hopkinsmedicine.org/healthlibrary/_procedures/neurological/craniotomy_92,p08767/ 3. The facility staff failed to document non-pharmacological interventions that were attempted with Resident #7 prior to the administration of the antipsychotic medication Haldol (1) on 1/25/17. Resident #7 was admitted to the facility on 6/23/14 and readmitted to the facility on 6/18/15. Resident #7's diagnoses included but were not limited to: dementia with lewy bodies (2), Parkinson's disease (3), generalized anxiety disorder and history of falling. Resident #7's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/24/16, coded the resident as being severely cognitively impaired, scoring a three out of a possible 15 on the brief interview for mental status. Review of Resident #7's clinical record revealed a physician's order dated 1/25/17 for a one time injection of one milligram of Haldol for combative behaviors. A nurse's note dated 1/25/17 documented, "Resident agitated and was attempting to hit staff. Haldol 1 mg (milligram) administered IM (intramuscular) @ (at) 0905 (9:05 a.m.); med (medication) effective..." Further review of nurses' notes dated 1/25/17 failed to document staff attempted non-pharmacological interventions with Resident	F 514		

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F 514	Continued From page 223 #7 prior to the administration of Haldol. On 2/23/17 at 2:45 p.m., an interview was conducted with LPN (licensed practical nurse) #11 (the nurse who signed the above note). LPN #11 was asked to describe the interventions provided to a resident who becomes combative. LPN #11 stated she tries to calmly talk to the resident and move the resident to another environment away from other residents. LPN #11 stated if non-pharmacological interventions don't work then staff turns to medication alternatives. LPN #11 stated at times, Resident #7 hits people. LPN #11 stated sometimes the resident will get a look on his face and ball up his fists so she talks to him and asks him if he needs anything. LPN #11 stated she also takes the resident to the medication cart near her and away from other residents. LPN #11 stated a lot of times, this action calms the resident but if not and the resident continues to swing his arms then she calls the physician who orders a one-time dose of Haldol. LPN #11 was asked if she documented the non-pharmacological interventions she tried with Resident #7 prior to the administration of Haldol on 1/25/17. LPN #11 looked at nurse's notes in the computer and stated, "I don't know if I documented what I tried." LPN #11 confirmed the non-pharmacological interventions should have been documented. On 2/27/17 at 3:44 p.m., an interview was conducted with RN (registered nurse) #5. RN #5 was asked where nurses document non-pharmacological interventions that are attempted prior to the administration of a one-time order of Haldol. RN #5 stated the non-pharmacological interventions should be documented in nurse's notes but probably wasn't	F 514		

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documented at times.

On 2/27/17 at 5:50 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

No further information was presented prior to exit.

(1) Haldol is an antipsychotic medication used in the treatment of schizophrenia and other disorders. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archiveid=49690

(2) "Lewy body disease is one of the most common causes of dementia in the elderly. Dementia is the loss of mental functions severe enough to affect normal activities and relationships. Lewy body disease happens when abnormal structures, called Lewy bodies, build up in areas of the brain..." This information was obtained from the website: https://medlineplus.gov/lewybodydisease.html

(3) "Parkinson's disease (PD) is a type of movement disorder. It happens when nerve cells in the brain don't produce enough of a brain chemical called dopamine..." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=parkinson%27s+disease